

**Estimating the Impact of Expanding
Medicaid Eligibility for Family
Planning Services**

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Occasional Report No. 28
August 2006

Acknowledgments

This report was written by Jennifer J. Frost, Adam Sonfield and Rachel Benson Gold, all of the Guttmacher Institute. The authors thank their colleagues at the Guttmacher Institute who provided guidance and assistance throughout this effort, including Susheela Singh, Lawrence B. Finer and Cory L. Richards. The authors also thank Humera Ahmed and Rachel K. Jones for assistance with data analysis, and Fannie Chen for important research support in the project's early phases. The report was copyedited by Rose MacLean, consultant. Kathleen Randall, Hector Duarte and Judith Rothman were responsible for layout and production.

Special thanks are due to the following individuals, who reviewed drafts of this work and provided invaluable comments: Claire D. Brindis and Diana Greene Foster, Center for Reproductive Health Research & Policy, University of California, San Francisco; Janet M. Bronstein, University of Alabama at Birmingham; and Melissa S. Kearney, The Brookings Institution. Additionally, the authors thank officials from numerous states across the country who provided data and information about their Medicaid family planning expansions and their broader Medicaid programs.

This effort was made possible by funding from The William and Flora Hewlett Foundation. The conclusions and opinions expressed in this publication, however, are those of the authors and the Guttmacher Institute.

Suggested citation: Frost JJ, Sonfield A and Gold RB, Estimating the Impact of Expanding Medicaid Eligibility for Family Planning Services, *Occasional Report*, New York: Guttmacher Institute, 2006, No. 28.

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ISBN: 0-939253-89-5

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Executive Summary

Background

In the 1980's, federal and state governments developed initiatives to expand Medicaid-covered prenatal, delivery and postpartum care to low-income women who were nonetheless ineligible for regular Medicaid coverage. Building on these efforts, several states in recent years have obtained permission from the federal government to expand eligibility for Medicaid-covered family planning services. Although some of these states have taken a limited approach and extended family planning coverage only to some women previously eligible for Medicaid, most of the recent expansions have paralleled those for pregnancy-related care: They grant Medicaid coverage for family planning services to residents solely on the basis of income—typically with a ceiling of 185% or 200% of the federal poverty level.

Evidence from states' own evaluations and from a federally commissioned evaluation of six expansions indicates that these income-based programs are having a real impact. The programs have expanded access to care and improved the geographic availability of family planning services while helping women prevent thousands of unintended pregnancies, unintended births and abortions. Because the cost of providing contraceptive services under these programs was far below the cost to Medicaid of the pregnancy-related care that otherwise would have been necessary, these programs produced millions of dollars in savings to the federal and state governments.

In this report, we examine the potential of this strategy, if adopted nationwide, to further help low-income women avoid unintended pregnancy, and we predict the number of abortions and unintended births that would be averted. Specifically, we estimate the potential impact of four scenarios for expanding eligibility for Medicaid-covered contraceptive services:

- requiring all states to expand eligibility for Medicaid-covered family planning services to women with incomes less than 200% of poverty (Scenario 200);

- giving each state the option to expand eligibility to women with incomes less than 200% of poverty (Scenario 200 Optional);
- requiring all states to expand eligibility to women with incomes less than 250% of poverty (Scenario 250); and
- requiring all states to establish parity between the income level used to determine eligibility for Medicaid-funded pregnancy-related services and the level that would be used for family planning services (Scenario Pregnancy Care).

Methods

We consider the experience of states that have already implemented a Medicaid family planning eligibility expansion to estimate the number of women who would utilize services under each of the four scenarios for further expanding Medicaid coverage. We use existing methodologies as the basis for estimating the impact of increased contraceptive use among program participants on the overall number of unintended pregnancies, abortions and unintended births that would be averted, and the cost savings that would result. Specifically, for each state and the District of Columbia, we draw on a wide array of data sources to:

- estimate the number of women who would be potential participants;
- predict how many of those women would make use of services;
- predict the change in contraceptive method use among program participants;
- estimate the number of unintended pregnancies, abortions and unintended births that would be averted;
- determine how many of the averted unintended births would have been Medicaid eligible;
- estimate the cost of a Medicaid birth and the total cost of Medicaid births averted;
- estimate the cost per user of Medicaid family planning services and the total cost of the expansion;

- and
- compare the two total costs to arrive at net savings.

Given the options available at various stages of the analysis, we typically choose the analytical approach that will lead to the most conservative estimate. For example, this methodology accounts for the fact that many potential participants—women not currently receiving Medicaid-covered family planning services but eligible for an expansion program—are already using some form of contraception, which, in some cases, they obtain from a publicly funded provider. Thus, for some women, an expansion program would merely substitute other sources that rely on public funding. To address this situation, we base our findings on a comparison of the mix of contraceptive methods used by all potential participants before and after joining the expansion. The impact of the program is therefore meas-

ured as the net effect of some nonusers becoming contraceptive users and some current users switching to more effective methods. In addition, this analysis does not try to gauge improvement in how correctly methods are used or any other beneficial impact of the reproductive health services that may result from a family planning eligibility expansion.

Finally, we do not attempt to address the critical supply-side issue of whether there will be a sufficient number of providers. The experience of existing expansions demonstrates both that this is an important determinant of success and that overcoming it is feasible.

Key Findings

In an expansion program’s third year of operation, when it may be considered reasonably mature, we estimate that between 2.6 million and 5.0 million additional women would receive Medicaid-covered family

Key Findings				
	Scenarios for Expanding Eligibility for Medicaid Coverage of Contraceptive Services			
	Nationwide, women up to 200% FPL	Optional, women up to 200% FPL	Nationwide, women up to 250% FPL	Nationwide, parity with pregnancy-related care
Expansion Participants	3,615,300	2,599,300	5,007,500	3,264,600
Unintended Pregnancies				
No. averted	521,700	375,100	722,600	471,100
Reduction in U.S. total	16.7%	12.0%	23.2%	15.1%
Reduction among low-income women	28.1%	20.2%	38.9%	25.4%
Abortions				
No. averted	210,300	151,200	291,200	189,900
Reduction in U.S. total	16.3%	11.7%	22.5%	14.7%
Reduction among low-income women	28.1%	20.2%	38.9%	25.4%
Unintended Births				
No. averted	248,900	178,900	344,700	224,700
Reduction in U.S. total	17.9%	12.9%	24.8%	16.2%
Reduction among low-income women	28.1%	20.2%	39.0%	25.4%
No. Medicaid-funded averted	238,200	174,300	271,300	224,700
Costs and Savings				
Medicaid costs averted (in billions)	\$2.47B	\$1.76B	\$2.81B	\$2.34B
Cost of expansion (in billions)	\$0.91B	\$0.63B	\$1.25B	\$0.82B
Net savings (in billions)	\$1.56B	\$1.13B	\$1.56B	\$1.53B
Net federal savings (in billions)	\$0.68B	\$0.49B	\$0.58B	\$0.68B
Net state savings (in billions)	\$0.88B	\$0.65B	\$0.98B	\$0.85B
Savings per \$1 spent	\$2.70	\$2.80	\$2.20	\$2.90
<i>Notes:</i> FPL=federal poverty level. Low-income women are those with incomes less than 200% FPL. Percent reduction in unintended pregnancies, abortions and unintended births are in relation to the U.S. total from the most recent available year (2001 in most cases and, for abortions overall, 2002). Estimates are for the annual impact in the third year of program operation. For additional notes and sources, see Table 3.1 of the full report.				

planning services under these four scenarios (see table). By providing new participants with family planning services and supplies, the programs would prevent between 375,000 and 723,000 unintended pregnancies—reducing the national incidence of unintended pregnancy by between 12% and 23% from levels in 2001, depending on the scenario. Among low-income women, the programs would have an even greater impact, leading to reductions in unintended pregnancy of between 20% and 39%.

Enabling women to avoid these pregnancies would prevent between 151,000 and 291,000 abortions, reducing the number of abortions in the United States by between 12% and 23% from 2002 levels. Reducing unintended pregnancies would also lead to between 179,000 and 345,000 fewer unintended births.

Most of these unintended births would have been funded through Medicaid at a cost of between \$1.8 billion and \$2.8 billion in Medicaid expenditures for pregnancy-related care. At the same time, the family planning services and supplies provided to enrollees under expansion programs would cost Medicaid between \$628 million and \$1.3 billion. Subtracting the cost of the expansion from the savings to Medicaid yields a net savings of between \$1.1 billion and \$1.6 billion in the third year, which would be split between the federal and state governments.

The narrowest of the scenarios—giving states the option to expand eligibility to women with incomes below 200% of poverty—would provide services to the fewest number of women, because not all states would be expected to take advantage of this option. Expanding the eligibility ceiling to 250% of poverty nationwide would have the greatest impact on participation and, therefore, on the numbers of unintended pregnancies, abortions and unintended births averted. However, because only 271,000 of the 345,000 unintended births averted under Scenario 250 would have been to mothers eligible for Medicaid-funded pregnancy-related care, this scenario has the lowest savings per dollar invested (\$2.25) among the scenarios modeled in this report.

Equalizing the eligibility levels for family planning and pregnancy-related care would be the most cost effective of the approaches considered here—saving an estimated \$2.87 for every dollar spent—because all women eligible for Medicaid-covered family planning under this approach would also be eligible for Medicaid-covered pregnancy-related care if they were to become pregnant.

Conclusions

These findings come at a particularly important moment. Recent data show a disturbing trend in contraceptive use, which fell considerably between 1995 and 2002 among low-income women. Over the same period of time, unintended pregnancy rates among poor women increased by 29%, even as they fell by 20% among women with higher incomes, and abortion rates have shown a similar trend. Poor women are now four times as likely to experience an unintended pregnancy as more affluent women, five times as likely to have an unintended birth and more than three times as likely to have an abortion.

The results presented here support an approach for addressing these critical issues that has the potential to be highly effective. Grounded in the experience of states that have pioneered expansion of Medicaid eligibility for family planning, these data show that scaling up such expansions to the national level could greatly expand access to services and reduce unintended pregnancy. Promotion of such an effort, therefore, holds out the promise of a meaningful reduction in the incidence of unintended birth and abortion. The fact that existing expansions have made progress toward these goals while saving millions of public dollars makes a nationwide effort additionally worthy of close examination by federal and state policymakers.

Chapter 1

Introduction

Half of all pregnancies in the United States today are unintended, and half of those end in abortion. Moreover, in recent years, the problem of unintended pregnancy has become more acute among low-income women. Nationwide, the 16% of women at risk of unintended pregnancy who live in poverty account for 30% of all unintended pregnancies that occur.¹

Unintended pregnancy can have far-reaching consequences for women, families and society at large.² According to numerous studies, closely spaced births and childbearing very early or late in women's reproductive lives can have adverse health consequences for mothers and their children. Unintended pregnancy—especially among teenagers—can hamper young women's ability to complete their education and participate effectively in the workforce.

Publicly funded family planning services are critical to enabling low-income women to avoid unintended pregnancy. These services prevent an estimated 1.3 million unintended pregnancies each year; without these services, our nation's abortion rate would be 40% higher than it is.³ Yet funding for these efforts has not kept pace with the need. In just four years (2000 to 2004), an estimated one million women joined the ranks of those needing publicly subsidized contraceptive care.⁴ Nonetheless, when inflation is taken into account, family planning funding declined or stagnated in half the states between 1994 and 2001.⁵ Moreover, four in 10 poor women of reproductive age (13–44) have no insurance coverage.⁶

This report looks at one way to address this situation and provide low-income women with coverage for the contraceptive services and supplies critical to avoiding unintended pregnancy. Over the past decade, several states have moved to expand Medicaid eligibility for family planning services to low-income women who would not otherwise be eligible for regular Medicaid coverage. In this report we examine the potential of this strategy, if adopted nationwide, to reduce unintended pregnancy, abortion and unintended birth.

Background

When Medicaid was first established in 1965, the low-income families covered generally were single mothers and their children receiving welfare cash assistance. In the 1980s, responding to research that showed both the importance and the cost-effectiveness of prenatal care, Congress broke the link between welfare and Medicaid for low-income pregnant women: It first allowed—and later required—states to extend eligibility for Medicaid-covered prenatal, delivery and postpartum care to all women with incomes less than 133% of the federal poverty level (\$16,600 for a family of three in 2006);⁷ this was far higher than most states' regular Medicaid eligibility ceilings.⁸ These services specifically include family planning services for up to 60 days after women give birth. At their option, states could expand eligibility for pregnancy-related services to women with incomes up to 185% of poverty or beyond. As a result of such expansions, Medicaid pays for nearly four in 10 of the births that occur in the United States each year; in some states, the program funds over half of all births.⁹

Building on the eligibility expansions for pregnancy-related care, almost half of the states in recent years have moved to expand eligibility for Medicaid family planning services as well. States seeking to adopt such a program require approval—generally through a research and demonstration waiver—from the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicaid. These waivers are limited in both scope and time, applying only to family planning and closely related services for an initial five-year period, although states may apply for an extension.

The existing state programs include coverage for the package of family planning services and supplies covered for other Medicaid recipients in the state. This generally includes the range of contraceptive methods as well as associated examinations and laboratory tests.¹⁰ A long-standing provision of the Medicaid

statute allows states to claim federal reimbursement for 90% of the cost of these services and supplies.¹¹ Although states may include other, closely related care in their package of benefits—such as treatment for STDs diagnosed in the course of a family planning visit—the state must claim federal reimbursement for this care at its regular rate. These rates range from 50% to 76% of the cost, depending on the state.¹² (States are reimbursed by the federal government for the cost of pregnancy-related care at these latter rates.)

As of June 2006, 23 states had sought and received federal approval to expand eligibility for Medicaid-covered family planning services and supplies; another three states had waiver applications pending.¹³ In general, the states' Medicaid family planning eligibility expansions have taken one of three routes (Table 1.1).

The first approach built on the expansions for pregnancy-related care, which require states to provide Medicaid-funded family planning services and supplies, as part of postpartum care, for 60 days after women give birth. Under this provision, unless women qualify for Medicaid under a different eligibility pathway, they lose Medicaid coverage after the 60-day postpartum period. Led by Rhode Island and South Carolina in 1993, six states currently have federal approval to continue coverage for family planning services, generally for two years after delivery, although Maryland extends coverage for five years.

Delaware and Illinois varied this approach and provide several years of continued Medicaid coverage for family planning for individuals leaving the Medicaid program for any reason, not just following childbirth. Only limited data are available on the impact of either of these types of efforts. Moreover, interest in these approaches appears to have waned.

Instead, states have more recently focused on a third approach: extending Medicaid coverage for family planning services to residents who had not been previously covered under the program at all. Beginning with Arkansas and South Carolina in 1997, 15 states have received federal permission to extend eligibility to residents solely on the basis of income, regardless of whether potential participants meet any of the other requirements for Medicaid coverage, such as being a low-income parent. This approach directly parallels the earlier expansions for pregnancy-related care. Most of these states extend coverage for family planning to women with incomes less than 185% or 200% of poverty. Unlike the more limited expansions for women leaving Medicaid, these programs do not impose a time limit on coverage. Five are limited to indi-

viduals aged 19 and older, and the remaining 10 cover all women of reproductive age.

Impact of Existing Expansions

Although many of the programs are too recent to have been properly evaluated, there is mounting evidence that the longer standing income-based programs are having a significant impact. A 2003 national evaluation of six family planning expansions, funded by CMS and conducted by the CNA Corporation and the schools of public health at Emory University and the University of Alabama at Birmingham, concluded that the six expansions studied (all but one of which were based on income) expanded access to care and improved the geographic availability of services.¹⁴

The positive impact of these programs on access to care is further suggested by a study of publicly funded family planning services nationwide. This study showed that publicly funded clinics in the seven states with income-based family planning expansions in operation in 2001 were able to meet more of the need for subsidized contraceptive services than clinics in other states. Clinics in these states served half of the women in need, while clinics in other states served only 40%. Between 1994 and 2001—years during which the seven expansions began—clinics in the states implementing expansions increased both the proportion of the need being met and the number of clients served by about one-quarter; clinics in states that had not expanded eligibility did not gain any ground.¹⁵

Moreover, data from the California expansion, which served about one million women in 2002, shows the ability of the program to enable women to prevent unintended pregnancy, thereby reducing the need for abortion. Researchers studying the program estimated that in 2002 the program prevented 213,000 unintended pregnancies, 45,000 of which would have occurred to teenagers. By preventing these pregnancies, the program helped women in California avoid roughly 82,000 abortions and 98,000 unintended births.¹⁶

In granting waivers, CMS requires that programs be “budget neutral” to the federal government; that is, they cannot cost the federal government more than it would have spent in the absence of the waiver. States that have obtained these waivers have argued that the cost of providing family planning services and supplies is a fraction of the cost of providing pregnancy-related services and infant care to beneficiaries who would otherwise have become pregnant and eligible for care supported by Medicaid. The CMS-funded study confirms this hypothesis: All six states studied not only met but sur-

passed that requirement, producing millions of dollars in savings to both the federal and state governments.¹⁷

Scenarios for Expansion

The initial impact demonstrated by existing programs has raised the question of the potential impact if expansions were adopted more broadly. The goal of this report is to examine four hypothetical scenarios for expanding eligibility on the basis of income. Each of these would require congressional action to change the Medicaid statute, and each would obviate the need for states to go through the cumbersome process of obtaining a federal waiver and periodic extensions in order to implement an expansion.

Under the first scenario, which we call Scenario 200, all states would be required to expand eligibility for Medicaid-covered family planning services to women with incomes less than 200% of poverty, the level chosen by most of the states that have recently applied for a waiver. Almost all states already cover women younger than 19 with incomes up to this level in the State Children's Health Insurance Program. For low-income parents, however, the current average income ceiling is only 43% of poverty.¹⁸ The impact would be even greater on childless adults, who are simply not eligible for Medicaid or other public insurance regardless of their income in about two-thirds of the states.¹⁹ States that have undertaken a more limited family planning expansion would be required to expand to this level under this scenario.

The second scenario (Scenario 200 Optional) would make it easier for states to expand eligibility to 200% of poverty but would let states decide whether to do so. Under this scenario, states would no longer have to negotiate the cumbersome process of obtaining a federal waiver in order to expand eligibility for family planning services. Instead, states would need only to amend their state Medicaid plan to reflect the change in the eligibility ceiling, a far easier endeavor. Nonetheless, while some states would probably implement the expansion, others would not. States considered likely to expand to 200% of poverty under this scenario include states that have an application pending with CMS, as well as states that are known to be actively exploring a waiver application or have political environments judged to be especially favorable to an expansion.

Under the third scenario (Scenario 250), all states would be required to expand the eligibility ceiling for family planning services and supplies under Medicaid to 250% of poverty, the maximum income level for subsidized services under the Title X national family

planning program. As with the first scenario, states that have already undertaken a more limited expansion would be expected to increase coverage to this level.

The final scenario (Scenario Pregnancy Care) would create parity between the income level each state currently uses to determine eligibility for pregnancy-related services and the level used for family planning. This approach would maximize the cost savings of the expansion by making all women who would be eligible for Medicaid-funded pregnancy-related care eligible for Medicaid-funded family planning if they want to avoid pregnancy. At present, the eligibility ceiling for pregnancy-related care is set below 200% of poverty in 34 states, at 200% of poverty in 13 states and the District of Columbia, and above that level in three states.²⁰

For each of these four scenarios, we draw on the experience of states that have already instituted eligibility expansions to estimate the impact in states that would expand under each scenario. Because experience has shown that programs have an initial period in which the effort is ramping up, we focus on the likely impact in the third year of the expansion, when the program can be expected to be reasonably mature. For each of these scenarios, we assume that new expansions would cover women of all reproductive ages, including those in their teens, and that eligibility for teens would be determined by their own income, as is the case for most existing expansions. We assume that the expansions currently in operation would not change how they determine eligibility for teenage women.

Expansion Services and Their Impact

Our examination assumes that the package of services provided to women who participate in a family planning expansion program will include those family planning services and supplies reimbursed at the 90% federal matching rate. Although states may choose to provide a broader range of reproductive and preventive health services as part of their program, estimation of the costs and benefits of such services is beyond the scope of this analysis.

Using our estimates of program participants under each scenario, we measure program impact by assessing the number of unintended pregnancies that would be averted and the resulting reduction in abortions and unintended births, both nationally and in each state. In addition, we estimate the number of unintended Medicaid-funded births that would be averted and the overall cost savings both nationally and in each state from these averted births. We do not attempt to look at costs

and savings at the level of individual women; these calculations are only made in aggregate.

In developing the methodology used to measure impact, we incorporated the facts that many of the women eligible for these programs are already practicing some form of contraception and some are already using publicly funded services. Our methodology accounts for this so-called substitution effect by comparing the mix of contraceptive methods used by all potential participants (including those who may have already received recent family planning care) with the mix of contraceptive methods used by women who received publicly funded contraceptive care in the past year. In this way, we evaluate the impact of these programs as the net effect of some nonusers becoming contraceptive users and some current users switching to more effective methods. This is one example of our general principle in this study to choose the analytical approach that would lead to the most conservative estimate when faced with several options.

We do not try to estimate any improvement in how effectively contraceptives are used, or any other beneficial impact of the reproductive health services that would likely be provided as part of the expansions under all scenarios. Moreover, states' ability to achieve significant results depends on such factors as the extent of their outreach efforts to clients and providers and an adequate supply of providers. This analysis does not attempt to address those issues, but the experience of states that have implemented expansions shows both that these factors are critical determinants of the success of the effort and that overcoming such obstacles is feasible.

In addition, this analysis does not account for potential changes in the national political and social environment that might hinder or help future family planning expansions. For example, it is possible that the continuing political controversy over immigration—including new requirements that Medicaid recipients provide documentation of citizenship—could dissuade some eligible women from joining a waiver program, or pose an obstacle to doing so.

TABLE 1.1. Current state Medicaid family planning expansions

State	(1)	(2)	(3)	(4)	(5)
	Basis for Eligibility			Initial implementation	Waiver expiration
	Losing coverage postpartum	Losing coverage for any reason	Based solely on income (% FPL)		
U.S. total	6	2	15	–	–
Alabama	–	–	133%	10/1/2000	9/30/2008
Arizona	2 years	–	–	8/1/1995	9/30/2006
Arkansas	–	–	200%*	9/1/1997	1/31/2009
California	–	–	200%	12/1/1999	6/30/2006
Delaware	–	2 years	–	1/1/1996	12/31/2006
Florida	2 years	–	–	9/1/1998	11/30/2006
Illinois	–	5 years	–	4/1/2004	3/31/2009
Iowa	†	–	200%	2/1/2006	1/31/2011
Maryland	5 years	–	–	2/1/1995	5/31/2008
Michigan	–	–	185%	3/1/2006	3/1/2011
Minnesota	–	–	200%	7/1/2006	6/30/2011
Mississippi	–	–	185%	10/1/2003	9/30/2008
Missouri	1 year	–	–	2/1/1999	3/1/2007
New Mexico	–	–	185%	7/1/1998	9/30/2006
New York	†	–	200%	10/1/1997‡	6/30/2006
North Carolina	–	–	185%	10/1/2005	9/30/2010
Oklahoma	–	–	185%	4/1/2005	3/31/2010
Oregon	–	–	185%	1/1/1999	10/31/2006
Rhode Island	2 years	–	–	8/1/1994	7/31/2008
South Carolina	–	–	185%	7/1/1994‡	1/24/2009
Virginia	2 years	–	–	10/1/2002	9/30/2007
Washington	–	–	200%	7/1/2001	6/30/2006
Wisconsin	–	–	185%	1/1/2003	12/31/2007

* Eligibility level was 133% FPL originally but was increased when the waiver was renewed in 2002. †State also extends Medicaid eligibility for family planning services to women following a Medicaid-funded delivery. ‡Initial waiver was for women losing coverage postpartum; implementation of the income-based expansion began on 10/1/2002 for New York and 6/1/1997 for South Carolina. Note: FPL = federal poverty level. Source: reference 13.

Chapter 2

Methodological Overview

This project estimates the numbers of pregnancies, births and abortions that could be averted, and the resulting cost savings, under four proposed income-based expansions to Medicaid family planning services. Once each of the four scenarios is established, most of the steps involved in making these estimates are identical, or nearly so. For each state and the District of Columbia, we:

- estimate the number of women who would be potential participants in the family planning expansion;
- predict how many of those women would make use of services;
- predict the net change in contraceptive method use among program participants;
- estimate the number of unintended pregnancies, abortions and unintended births that would be averted as a result of this net change in users and methods used;
- determine how many of the averted births would have been Medicaid eligible;
- estimate the cost of a Medicaid birth and the total cost of Medicaid births averted;
- estimate the cost per user of Medicaid family planning services and the total cost of the expansion; and
- compare the two total costs to arrive at net savings.

In this chapter we present the methodology step by step, rather than for each scenario, with differences among scenarios noted throughout. A comprehensive description of the methodology is provided in Appendix A.

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

- the Guttmacher Institute’s 2002 and 2004 estimates of women aged 13–44 in need of contraceptive services and supplies;
- state-level data on income and insurance coverage from the Current Population Survey (CPS), combining the most recent three years of data

(2003–2005) for all state estimates;

- national-level data on contraceptive use and insurance coverage from the 2002 National Survey of Family Growth (NSFG) and on contraceptive failure rates from the 1995 NSFG;
- state-level data on Medicaid family planning use and costs from the Medicaid Statistical Information System (MSIS) for 2003;
- data for 22 states from available family planning waiver applications and evaluations;
- state-level indices of Medicaid fee-for-service costs and managed care capitation rates;
- Guttmacher estimates of unintended pregnancies, abortions and unintended births;
- government data on the federal poverty level and the Consumer Price Index; and
- data on states’ eligibility ceilings for Medicaid-covered pregnancy care and for existing Medicaid family planning expansions.

Establishing the Four Scenarios

For Scenarios 200 and 250, we assumed that every state would provide Medicaid coverage for family planning services to women with incomes less than the respective eligibility ceilings (200% and 250% of poverty). Similarly, for Scenario Pregnancy Care, we assumed that each state would provide coverage for family planning services to women with incomes up to the same level used for pregnancy-related Medicaid care.²¹

For Scenario 200 Optional, we made several assumptions about which states would choose to expand coverage if the process were made easier. We assumed that states with existing income-based expansions would not change their programs. The 20 states that we assumed would expand include eight states with limited, non-income-based expansions; six states in the process of applying for an expansion; and six states that we knew to be exploring a waiver application or that had political environments deemed especially favorable to an expansion (see Appendix A).

Potential Participants Under the Expansion

The first step in our study was to estimate how many women would be newly eligible for and likely to take advantage of Medicaid coverage of family planning under each of the four scenarios. In doing so, we made a number of assumptions that were based on the nature of the proposed expansions, the rules by which Medicaid generally is governed and the way most of the existing expansions operate:

- Family planning services would only be used by women in need of contraceptive services and supplies, defined as women who were sexually active, of reproductive age (13–44), able to become pregnant, and not pregnant, postpartum or trying to become pregnant during the last 12 months.
- Women enrolled for the entire past year in private insurance or public health coverage (including regular Medicaid) would be unlikely to seek services in a family planning expansion and should thus be excluded from estimates of potential program participants.
- New expansions would cover women of reproductive age, including adolescents; women younger than 19 (considered minors under Medicaid) would be eligible for a family planning expansion on the basis of their own income, rather than their family’s income, and their own income would be low enough for them to qualify for services under all scenarios.
- Expansions currently in operation would only change in regard to eligibility level; they would not change in regard to whether they include adolescents or how they determine eligibility for adolescents.

Following these assumptions, we identified the number of women aged 13–18 and 19–44 in each state who were in need of family planning services in 2004, drawing on the most recent Guttmacher Institute estimates of women in need of contraceptive services and supplies at the state level.²² Next we estimated how many of the adult women had a family income below the cutoff point for each scenario, assuming an even distribution of women between income levels when the available data did not match the cutoff point (Table 2.1). Finally, we estimated the proportions of in-need, income-eligible adults and of in-need adolescents who were uninsured for some period during the past year (i.e., they had neither public nor private health insurance). For that last step, we drew on state-level data on the percentage of women of reproductive age who were uninsured from

the CPS²³ and adjusted these data using national estimates from the NSFG²⁴ to estimate the proportion who were uninsured for some period during the past year (Table 2.2; see Appendix A for details).

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

Women Who Would Use Services

To estimate how many potential participants would actually use family planning services under an expansion program, we drew on data from the eight states that had available program evaluations for existing Medicaid family planning expansions.²⁵

We divided the actual number of program users reported by each state by the number of women we estimated to be potential participants for each state’s expansion (a figure generated following the methodology described in the previous section). This provided us with an estimate of the rate of use among potential participants for each state in each year of its expansion. We then averaged the rates of use for the third full year of each state’s expansion to arrive at a national estimate of the rate of use among potential participants for a relatively mature program, given that programs require several years of growth before even approaching their full potential. (Notably, several existing expansions have continued to grow beyond their third year; our estimates, as a result, can be considered conservative.) Finally, we multiplied the average national rate by the number of potential participants in each state under each scenario to estimate the number of expansion participants.

For states that have already implemented an income-based family planning expansion, the estimated number of participants reflects only those who would be new to the program because of the policy change under each scenario. Because the number of women participating in the more limited expansions (e.g., those for women leaving Medicaid after giving birth) is quite small, we did not account for these limited expansions in our estimates.

The current group of expansion states is heterogeneous in size, region, political climate and other characteristics, and therefore provides a reasonable national estimate of the rate of use among potential

participants that may be generalized to states that newly expand their Medicaid coverage for family planning. Although it is likely that actual rates of participation will vary from state to state, the data from existing expansions do not provide us with any guidance in predicting this variation. States' efforts at outreach, to both potential participants and potential providers, would likely be one critical factor in determining how well states' programs meet their potential.

Contraceptive Use Among Program Participants

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

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

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

As expected, compared with current clients of publicly funded providers, lower proportions of potential program participants used effective contraceptive methods (e.g., 26% vs. 39% used the pill and 14% vs. 24% used injectables); a higher proportion used no method (22% vs. none). However, most potential participants were using some method of contraception, and many were already using effective methods.

Pregnancies, Abortions and Births Averted

Next we estimated the number of unintended pregnancies that increased use of effective contraceptives would prevent. We applied method-specific failure rates²⁶ to the method mix used by the two national subpopulations that represent women before and after program implementation (see Appendix A). By subtracting the number of unintended pregnancies expected among women after joining the program from those expected among potential participants without the program expansion, we calculated the net impact upon our hypothetical population of expected users. (Note that the number of expected unintended pregnancies among potential participants prior to the program—and the subsequent net impact—would have been much higher had we assumed that potential participants were not using any method or were only using nonprescription methods prior to joining the program. Instead, we used the more realistic and more conservative approach just described.)

Finally, we used the net number of unintended pregnancies averted to produce a national-level estimate of the number of unintended pregnancies averted per expansion participant. This figure was then applied to the estimated number of participants in each state under each scenario to estimate total unintended pregnancies averted by the program.

Of the unintended pregnancies averted, we assumed that 40% would have resulted in abortion and 48% in birth, given the actual national distribution of unintended pregnancy outcomes among women with incomes below 200% of poverty in 2001.²⁷ (The remainder of the pregnancies would result in spontaneous pregnancy losses.)

Medicaid Births Averted

For Scenario Pregnancy Care, all of the births averted would be, by definition, to women who would also be eligible for pregnancy-related coverage under Medicaid. Under this scenario, every birth averted would have been eligible for coverage by Medicaid.

For the other three scenarios, however, some potential participants have incomes above the cutoff for

pregnancy care, and the cost of averted births to those women cannot be considered government savings. Therefore, we calculated additional estimates of the number of women who would be both a potential participant for a family planning expansion and eligible for Medicaid-funded pregnancy-related care. In calculating these estimates, we had to factor in an additional complication: A pregnant woman is counted as two people in determining whether her income qualifies her for Medicaid, a fact that effectively increases each state's eligibility level for pregnancy care (see Appendix A). After estimating the number of potential family planning participants who would be eligible for Medicaid-funded pregnancy-related care, we estimated the number of unintended births averted under each scenario that would have occurred to this group of women.

Cost of Medicaid Births

Data on the cost of a Medicaid-funded birth (defined as the cost of prenatal care, delivery, postpartum care and one year of medical care for the infant) were not available for every state, but were available for 22 states from their applications for and evaluations of Medicaid family planning expansions.²⁸ From these data, we estimated the cost of a Medicaid-funded birth for the remaining states.

First we updated the existing cost data to reflect 2005 dollars, using the Consumer Price Index for medical care, and calculated an average cost per birth for these 22 states.²⁹ We used this average to calculate state-level estimates of cost per birth for the remaining 28 states and the District of Columbia (Table 2.3). In making these estimates, we adjusted for state-level differences in medical costs, using, as appropriate, one index reflecting Medicaid fee-for-service (FFS) physician fees³⁰ and one reflecting statewide Medicaid managed care capitation rates.³¹ Finally, we multiplied the number of unintended Medicaid births averted by the cost per birth to arrive at savings from Medicaid births averted for each state under each scenario.

We did not estimate any government savings from averted abortions. Because few abortions are covered under Medicaid and because of the relative costs of births and abortions, any such savings would be negligible in comparison to the savings from averted births (see Appendix A).

Cost of the Family Planning Expansion

In contrast to information on Medicaid-funded births, data on Medicaid family planning services were available for every state through MSIS.³² Using 2003 data for women aged 13–44, we divided the total FFS family planning spending reported in MSIS by the total number of beneficiaries who received FFS family planning services to calculate Medicaid family planning costs per user. After identifying problematic data for five jurisdictions, we estimated their costs per user as the average among the remaining states, adjusted for state-level variation in FFS costs. Next we adjusted the data to reflect 2005 dollars, using the Consumer Price Index for medical care. It should be noted that these program costs reflect only those services that states may claim at the special 90% matching rate for family planning services (see Introduction). To account for outreach and administration, as well as other costs not captured by these data, we inflated each state's cost per user by 10%, an estimate we judge to be conservatively high on the basis of existing program data (Table 2.3). Finally, we multiplied the number of expected expansion participants by the family planning cost per user to calculate program costs for each state under each scenario.

Although the 10% adjustment addresses some potentially missing administrative costs of implementing a program, many states may choose to provide participants with additional, related clinical services (e.g., treatment for STDs diagnosed in the course of a family planning visit). In addition, some states may choose to provide services to men. In such cases, the overall cost of a state's program may be higher than our estimate. Those additional services may also generate additional savings for the government; such costs and savings are beyond the scope of this study and are not reflected in the results presented in Chapter 3.

Net Savings from the Expansion

The final step in our study was simple: We subtracted the family planning program costs from the savings produced by averted Medicaid births. That left us with the net savings from the expansion for each state under each scenario. In addition, we apportioned the costs and savings under each scenario to the federal and state governments (see Appendix A).

TABLE 2.1. Total number of women of reproductive age and women in need of contraceptive services and supplies, by age and income-based eligibility level, all according to state, 2004

State	(1)	(2)	(3)	(4)	(5)	(6)
	Aged 13–44	Aged 13–44 in need	aged 13–18	Among women in need, those:		
				aged 19–44 with incomes		
				<200% FPL	<250% FPL	< pregnancy care level
U.S. total	66,261,000	34,413,400	3,648,400	10,276,600	13,126,300	9,554,000
Optional states	28,034,500	14,600,000	1,568,300	4,102,600	–	–
Alabama	1,016,400	495,900	60,300	171,200	213,100	119,600
Alaska	150,400	67,100	7,600	16,800	21,900	14,300
Arizona	1,264,100	662,700	64,700	228,600	286,600	149,300
Arkansas	602,800	282,800	35,700	98,500	126,700	98,500
California	8,292,600	4,428,200	442,700	1,452,900	1,808,500	1,452,900
Colorado	1,061,500	546,900	47,800	143,600	188,800	143,600
Connecticut	765,500	429,000	46,500	92,500	119,300	85,400
Delaware	189,300	97,300	9,700	24,400	33,000	24,400
District of Columbia	142,400	82,700	5,600	25,000	30,600	25,000
Florida	3,635,500	1,778,700	199,000	507,300	663,800	466,300
Georgia	2,111,200	1,028,100	116,800	294,300	389,500	294,300
Hawaii	263,900	137,100	11,400	35,300	45,800	32,300
Idaho	312,600	149,200	15,100	53,700	69,900	31,500
Illinois	2,896,600	1,549,000	166,900	413,300	525,100	413,300
Indiana	1,392,800	731,800	76,900	219,300	282,300	163,200
Iowa	642,200	329,500	34,500	105,400	134,600	105,400
Kansas	607,000	311,300	34,600	97,500	125,800	70,500
Kentucky	931,500	446,900	48,100	159,200	198,500	148,200
Louisiana	1,046,400	512,700	67,500	180,500	222,800	180,500
Maine	284,000	155,100	17,000	49,300	62,100	49,300
Maryland	1,280,900	650,200	70,900	135,700	183,000	183,000
Massachusetts	1,474,800	867,800	79,000	182,800	229,900	182,800
Michigan	2,265,500	1,197,600	132,000	362,900	456,900	336,700
Minnesota	1,167,200	610,200	62,200	147,800	196,900	221,500
Mississippi	669,900	310,700	43,600	110,200	139,800	101,500
Missouri	1,290,700	675,500	72,600	218,400	280,000	201,300
Montana	196,300	90,900	9,000	36,500	45,100	23,700
Nebraska	387,600	200,200	21,800	65,200	85,900	59,500
Nevada	518,700	273,500	24,400	90,700	115,700	60,300
New Hampshire	291,800	160,400	17,400	30,500	41,900	27,800
New Jersey	1,921,400	1,080,600	114,300	198,200	259,700	198,200
New Mexico	423,600	210,800	25,000	86,500	105,200	80,100
New York	4,385,900	2,501,500	258,400	735,600	923,100	735,600
North Carolina	1,935,500	934,600	104,600	295,400	386,900	272,200
North Dakota	137,800	70,700	7,500	25,600	32,600	15,800
Ohio	2,539,000	1,334,600	143,100	393,000	506,100	290,500
Oklahoma	778,500	373,200	43,900	123,700	160,600	112,700
Oregon	788,400	401,300	34,300	140,500	177,600	129,800
Pennsylvania	2,666,000	1,501,800	163,700	429,400	545,400	398,200
Rhode Island	247,000	146,900	13,600	45,000	55,500	55,500
South Carolina	949,900	473,900	55,500	161,500	215,300	147,600
South Dakota	167,400	83,700	9,600	33,000	41,000	22,400
Tennessee	1,335,300	646,100	71,600	199,100	254,100	184,900
Texas	5,271,200	2,558,600	281,000	860,700	1,100,200	791,700
Utah	586,800	314,900	26,600	93,000	126,000	54,800
Vermont	135,200	71,100	8,300	19,200	25,300	19,200
Virginia	1,703,600	851,900	90,900	207,400	276,500	150,900
Washington	1,412,000	728,100	61,300	210,900	266,800	194,800
West Virginia	380,700	175,200	19,900	65,800	80,800	50,500
Wisconsin	1,234,300	643,400	68,800	185,300	240,400	170,600
Wyoming	109,200	51,300	5,200	18,800	23,600	12,200
Column sources and formulas	B1-col. 1	B1-col. 2	A1-col. 6	A2-col. 10	A3-col. 8	A4-col. 6

Notes for all tables: Column sources and formulas refer to other columns in the existing table (e.g., "col. 3" is short for column 3); to columns in other tables (e.g., "A2-col. 1" is short for Table A2, column 1); and to outside sources (e.g., "ref. 18" directs the reader to reference 18 from the References "FN†" directs the reader to a footnote at the bottom of the table). FPL = federal poverty level. Data presented are often rounded: Numbers of women, for example, are typically rounded to the nearest hundred, and percentages are typically rounded to two decimal places. All calculations were performed using unrounded data. Data presented may not sum to the totals because of rounding. For tables presenting state-level data, all calculations were performed at the state level, except when specifically noted, and national sums and averages are presented for illustration purposes.

TABLE 2.2. Percentages of adolescent and adult women uninsured at all during the year, and total number of potential participants in expanded Medicaid family planning under different scenarios, by state, 2004

State	(1)		(2)	(3)	(4)	(5)
	% uninsured at all during year		Aged 13–44, in need, income eligible and uninsured at all during year	Scenarios 200 and 200 Optional	Scenario 250	Scenario Pregnancy Care
	Aged 13–18	Aged 19–44 with incomes <200% FPL				
U.S. total	30.76	59.36	7,126,800	8,795,100	6,698,000	
Optional states	–	–	3,114,800	–	–	–
Alabama	24.70	54.19	107,700	130,400	79,700	
Alaska	29.21	61.28	12,500	15,600	11,000	
Arizona	44.76	59.59	165,200	199,700	117,900	
Arkansas	31.47	64.08	74,300	92,400	74,300	
California	36.28	63.35	1,081,100	1,306,400	1,081,100	
Colorado	33.84	68.02	113,900	144,600	113,900	
Connecticut	25.56	42.14	50,900	62,200	47,900	
Delaware	19.31	42.14	12,100	15,800	12,100	
District of Columbia	29.71	39.45	11,500	13,700	11,500	
Florida	46.78	69.23	444,300	552,700	415,900	
Georgia	29.06	66.09	228,400	291,400	228,400	
Hawaii	19.60	34.92	14,600	18,200	13,500	
Idaho	29.41	61.82	37,600	47,700	23,900	
Illinois	26.73	54.42	269,500	330,400	269,500	
Indiana	29.04	54.48	141,800	176,100	111,200	
Iowa	14.50	51.15	58,900	73,800	58,900	
Kansas	16.34	53.49	57,800	72,900	43,400	
Kentucky	22.28	56.55	100,700	123,000	94,500	
Louisiana	37.07	73.96	158,500	189,800	158,500	
Maine	20.18	33.19	19,800	24,000	19,800	
Maryland	25.51	64.39	105,500	135,900	135,900	
Massachusetts	22.09	40.07	90,700	109,600	90,700	
Michigan	21.10	44.54	189,500	231,400	177,800	
Minnesota	18.24	38.54	68,300	87,200	96,700	
Mississippi	27.95	60.26	78,600	96,500	73,400	
Missouri	14.85	47.62	114,800	144,100	106,700	
Montana	39.81	62.65	26,500	31,800	18,500	
Nebraska	15.00	49.73	35,700	46,000	32,800	
Nevada	40.01	69.62	72,900	90,300	51,800	
New Hampshire	16.37	60.97	21,400	28,400	19,800	
New Jersey	28.69	64.32	160,300	199,800	160,300	
New Mexico	36.55	73.48	72,700	86,400	68,000	
New York	21.88	50.67	429,200	524,300	429,200	
North Carolina	33.55	61.72	217,400	273,900	203,100	
North Dakota	20.84	36.17	10,800	13,300	7,300	
Ohio	20.10	48.06	217,600	272,000	168,400	
Oklahoma	51.48	65.82	104,000	128,300	96,800	
Oregon	34.05	62.82	100,000	123,200	93,200	
Pennsylvania	20.50	49.31	245,300	302,500	229,900	
Rhode Island	14.76	37.83	19,000	23,000	23,000	
South Carolina	21.79	51.68	95,500	123,400	88,400	
South Dakota	21.18	40.42	15,400	18,600	11,100	
Tennessee	18.09	40.62	93,800	116,100	88,100	
Texas	59.82	84.86	898,500	1,101,800	840,000	
Utah	19.60	46.74	48,700	64,100	30,800	
Vermont	17.57	32.29	7,700	9,600	7,700	
Virginia	26.76	64.02	157,100	201,300	120,900	
Washington	25.63	53.79	129,100	159,200	120,500	
West Virginia	27.15	65.35	48,400	58,200	38,400	
Wisconsin	16.80	36.07	78,400	98,300	73,100	
Wyoming	26.76	60.70	12,800	15,700	8,800	
Column sources and formulas	A5-col. 3	A5-col. 6	col. 1 * 2.1-col. 3 + col. 2 * 2.1-col. 4	col. 1 * 2.1-col. 3 + col. 2 * 2.1-col. 5	col. 1 * 2.1-col. 3 + col. 2 * 2.1-col. 6	

TABLE 2.3. Adjusted costs per Medicaid birth and Medicaid family planning user, 2005

State	(1) Cost per Medicaid birth	(2) Cost per Medicaid family planning user, inflated
U.S. total	\$10,948	\$257
Alabama	\$8,325	\$224
Alaska	\$22,944	\$355
Arizona	\$9,696	\$398
Arkansas	\$10,768	\$261
California	\$8,592	\$203
Colorado	\$10,199	\$576
Connecticut	\$12,063	\$193
Delaware	\$11,657	\$216
District of Columbia	\$10,964	\$200
Florida	\$10,234	\$92
Georgia	\$11,371	\$137
Hawaii	\$10,535	\$227
Idaho	\$12,277	\$165
Illinois	\$8,855	\$383
Indiana	\$9,946	\$211
Iowa	\$13,909	\$199
Kansas	\$10,215	\$246
Kentucky	\$11,099	\$167
Louisiana	\$13,961	\$276
Maine	\$8,956	\$362
Maryland	\$12,340	\$286
Massachusetts	\$12,837	\$328
Michigan	\$13,014	\$105
Minnesota	\$12,180	\$187
Mississippi	\$5,899	\$188
Missouri	\$9,011	\$285
Montana	\$11,371	\$261
Nebraska	\$12,277	\$254
Nevada	\$12,620	\$333
New Hampshire	\$10,928	\$275
New Jersey	\$8,151	\$210
New Mexico	\$9,754	\$331
New York	\$12,849	\$261
North Carolina	\$8,753	\$372
North Dakota	\$12,963	\$277
Ohio	\$10,369	\$450
Oklahoma	\$8,800	\$216
Oregon	\$7,887	\$243
Pennsylvania	\$4,843	\$221
Rhode Island	\$12,444	\$159
South Carolina	\$9,822	\$300
South Dakota	\$10,566	\$220
Tennessee	\$10,948	\$257
Texas	\$11,093	\$208
Utah	\$9,932	\$167
Vermont	\$11,271	\$217
Virginia	\$9,392	\$381
Washington	\$13,218	\$221
West Virginia	\$12,255	\$88
Wisconsin	\$9,903	\$142
Wyoming	\$14,088	\$590
Column sources and formulas	A13-col. 10	A14-col. 7

Chapter 3

Key Findings

For each of the four expansion scenarios, we present estimates of the number of women who would use family planning services and the number of unintended pregnancies, abortions and unintended births that would be averted, as well as the cost savings that would result.

Drawing on the experience of states that have already expanded Medicaid eligibility for family planning, we assumed that the efforts would have an initial period during which the program is developing and enrollment and impact are lower. For this reason, the estimates presented here are for the third year of the expansion programs' operation, when efforts could be expected to be reasonably mature. All estimates are in 2005 dollars, and all are for a one-year period.

It should be noted that many of the states that have already expanded eligibility put considerable effort into program implementation and outreach to potential participants and providers. The strength of these efforts would be a major determinant of the impact that future program expansions could be expected to have; in the absence of such efforts, the impact would likely be lower. Accordingly, we inflated the cost per user of family planning services in our estimates by 10% to provide a conservative estimate of these important costs.

In addition, it is important to remember that our findings measure only the impact of new eligibility expansions and exclude women covered under existing expansion programs. Therefore, by definition, almost all of the new family planning participants expected under each scenario would be from those states that either have not adopted any sort of expansion as of June 2006 or have adopted a program limited to women exiting the regular Medicaid program. In some cases, the eligibility criteria for a scenario would result in an additional expansion in one or more of the 15 states that had already adopted an income-based expansion; in those cases, we include an estimate of the participants resulting from this additional expansion.

This report looks only at the impact of changes in contraceptive use among new program participants—the net effect of some nonusers becoming contraceptive users and some current users switching to more effective methods. In so doing, it accounts for the fact that for some new program participants, the program will merely be taking on costs that had been paid for through other public or private sources. The report does not attempt to estimate the impact of the entire range of health care services typically provided as part of a family planning visit. In addition, the estimated savings are only those from Medicaid-funded births that would be averted because of the family planning services that are provided; no savings from averted Medicaid-funded abortion services are included.

Tables that display additional findings are included in the appendix. These tables show estimates for the first full year of programs' operation and for universal participation among women estimated to be potential participants, a level reached by several existing expansions by the fifth or sixth year. They also show estimates that apportion both costs and savings to the federal and state governments.

Scenario 200

All states would be required to extend eligibility for Medicaid-covered family planning services and supplies to women with incomes less than 200% of poverty (Tables 3.1 and 3.2).

- In their third year of operation, state programs would provide Medicaid-covered family planning to an additional 3.6 million women as a result of the eligibility expansion.
- By providing these family planning services and supplies, this effort would help women to avoid 522,000 unintended pregnancies that would otherwise occur, reducing the number of unintended pregnancies in the United States by 17% from what it was in 2001.³³ Unintended pregnancies among low-income women (i.e., those with in-

comes less than 200% of poverty) would be reduced by 28%.

- Enabling women to avoid these unintended pregnancies would avert 210,000 abortions, reducing the number of abortions in the United States by 16% from what it was in 2002.³⁴
- Preventing these pregnancies would also avert 249,000 unintended births, of which 238,000 would have been funded through Medicaid. This would result in a savings of \$2.5 billion in Medicaid expenditures for pregnancy-related care.
- The family planning services and supplies provided to enrollees under this expansion would cost Medicaid \$914 million.
- Subtracting the cost of the family planning expansion (\$914 million) from the savings to Medicaid (\$2.5 billion) yields a net savings of \$1.6 billion in the third year—\$0.68 billion to the federal government and \$0.88 billion to the states.
- Dividing the savings by the cost shows that every dollar spent would save \$2.70.

Scenario 200 Optional

States would have the option to extend eligibility for Medicaid-covered family planning services and supplies to women with incomes less than 200% of poverty without having to obtain a federal waiver (Tables 3.1 and 3.3).

- If states could expand eligibility for Medicaid-covered family planning services and supplies without first having to obtain a waiver from the federal government, 20 states are considered likely to extend coverage to women with incomes less than 200% of poverty. (See Appendix A for a discussion of the methodology for determining which states are likely to expand eligibility if given the option to do so without having to obtain a waiver.)
- In their third year of operation, these new state programs would provide Medicaid-covered family planning to an additional 2.6 million women as a result of the eligibility expansion.
- By providing these family planning services and supplies, this effort would help women to avoid 375,000 unintended pregnancies that would otherwise occur, reducing the number of unintended pregnancies in the United States by 12% from what it was in 2001, and by 20% among low-income women.
- Enabling women to avoid these unintended pregnancies would avert 151,000 abortions, reducing the number of abortions in the United States by

12% from what it was in 2002.

- Preventing these pregnancies would also avert 179,000 unintended births, of which 174,000 would have been funded through Medicaid. This would result in a savings of \$1.8 billion in Medicaid expenditures for pregnancy-related care.
- The family planning services and supplies provided to enrollees under this expansion would cost Medicaid \$628 million.
- Subtracting the cost of the family planning expansion (\$628 million) from the savings to Medicaid (\$1.8 billion) yields a net savings of \$1.1 billion in the third year—\$0.49 billion to the federal government and \$0.65 billion to the states.
- Dividing the savings by the cost shows that every dollar spent would save \$2.81.

Scenario 250

All states would be required to extend eligibility for Medicaid-covered family planning services and supplies to women with incomes less than 250% of poverty (Tables 3.1 and 3.4).

- In their third year of operation, state programs would provide Medicaid-covered family planning to an additional five million women as a result of the eligibility expansion.
- By providing these family planning services and supplies, this effort would help women to avoid 723,000 unintended pregnancies that would otherwise occur, reducing the number of unintended pregnancies in the United States by 23% from what it was in 2001, and by 39% among low-income women.
- Enabling women to avoid these unintended pregnancies would avert 291,000 abortions, reducing the number of abortions in the United States by 23% from what it was in 2002.
- Preventing these pregnancies would also avert 345,000 unintended births, of which 271,000 would have been funded through Medicaid. This would result in a savings of \$2.8 billion in Medicaid expenditures for pregnancy-related care.
- The family planning services and supplies provided to enrollees under this expansion would cost Medicaid \$1.3 billion.
- Subtracting the cost of the family planning expansion (\$1.3 billion) from the savings to Medicaid (\$2.8 billion) yields a net savings of \$1.6 billion in the third year—\$0.58 billion to the federal government and \$0.98 billion to the states.

- Dividing the savings by the cost shows that every dollar spent would save \$2.25.

Scenario Pregnancy Care

All states would be required to set the eligibility level for Medicaid-covered family planning at the same level used to determine eligibility for Medicaid-covered pregnancy-related care (Tables 3.1 and 3.5).

- In their third year of operation, state programs would provide Medicaid-covered family planning to an additional 3.3 million women as a result of the eligibility expansion.
- By providing these family planning services and supplies, this effort would help women to avoid 471,000 unintended pregnancies that would otherwise occur, reducing the number of unintended pregnancies in the United States by 15% from what it was in 2001, and by 25% among low-income women.
- Enabling women to avoid these unintended pregnancies would avert 190,000 abortions, reducing the number of abortions in the United States by 15% from what it was in 2002.
- Preventing these pregnancies would also avert 225,000 unintended births, all of which would have been funded through Medicaid. This would result in a savings of \$2.3 billion in Medicaid expenditures for pregnancy-related care.
- The family planning services and supplies provided to enrollees under this expansion would cost Medicaid \$816 million.
- Subtracting the cost of the family planning expansion (\$816 million) from the savings to Medicaid (\$2.3 billion) yields a net savings of \$1.5 billion in the third year—\$0.68 billion to the federal government and \$0.85 billion to the states.
- Dividing the savings by the cost shows that every dollar spent would save \$2.87.

TABLE 3.1. Key national findings for all four scenarios, third full year

Measure	(1)	(2)	(3)	(4)
	Scenario 200	Scenario 200 Optional	Scenario 250	Scenario Pregnancy Care
No. of expansion participants	3,615,300	2,599,300	5,007,500	3,264,600
No. of unintended pregnancies averted	521,700	375,100	722,600	471,100
% reduction in unintended pregnancies	16.72	12.02	23.15	15.09
% reduction among women with incomes <200% FPL	28.09	20.20	38.91	25.37
No. of abortions averted	210,300	151,200	291,200	189,900
% reduction in abortions	16.26	11.69	22.52	14.69
% reduction among women with incomes <200% FPL	28.12	20.22	38.94	25.39
No. of unintended births averted	248,900	178,900	344,700	224,700
% reduction in unintended births	17.93	12.89	24.83	16.19
% reduction among women with incomes <200% FPL	28.13	20.22	38.95	25.39
No. of unintended Medicaid births averted	238,200	174,300	271,300	224,700
Savings from unintended Medicaid births averted (in 000s)	\$2,470,100	\$1,762,900	\$2,813,700	\$2,341,700
Spending on expansion services (in 000s)	\$913,600	\$627,900	\$1,253,200	\$816,300
Net savings (in 000s)	\$1,556,500	\$1,134,900	\$1,560,500	\$1,525,500
Net federal savings (in 000s)	\$679,000	\$489,600	\$576,700	\$678,800
Net state savings (in 000s)	\$877,500	\$645,300	\$983,800	\$846,700
Savings per \$1 spent	\$2.70	\$2.81	\$2.25	\$2.87

Note: Percent reduction in unintended pregnancies, abortions and unintended births are in relation to the U.S. total from the most recent available year (2001 in most cases and, for abortions overall, 2002). *Sources:* Tables 3.2 to 3.5 and Tables A23 to A26; references 27 and 34; and Guttmacher Institute, special tabulations of the Institute's 2001 unintended pregnancy analysis, 2006.

Notes for all tables: Column sources and formulas refer to other columns in the existing table (e.g., "col. 3" is short for column 3); to columns in other tables (e.g., "A2-col. 1" is short for Table A2, column 1); and to outside sources (e.g., "ref. 18" directs the reader to reference 18 from the References; "FN†" directs the reader to a footnote at the bottom of the table). FPL = federal poverty level. Data presented are often rounded: Numbers of women, for example, are typically rounded to the nearest hundred, and percentages are typically rounded to two decimal places. All calculations were performed using unrounded data. Data presented may not sum to the totals because of rounding. For tables presenting state-level data, all calculations were performed at the state level, except when specifically noted, and national sums and averages are presented for illustration purposes.

TABLE 3.2. Key findings for Scenario 200, third full year

State	(1) No. of expansion participants	(2) No. of unintended pregnancies averted	(3) No. of abortions averted	(4) No. of unintended births averted	(5) No. of unintended Medicaid births averted	(6) Savings from unintended Medicaid births averted (in 000s)	(7) Spending on expansion services (in 000s)	(8) Net savings (in 000s)
U.S. total	3,615,300	521,700	210,300	248,900	238,200	\$2,470,100	\$913,600	\$1,556,500
Alabama*	23,300	3,400	1,400	1,600	500	\$3,800	\$5,200	-\$1,400
Alaska	10,400	1,500	600	700	700	\$16,500	\$3,700	\$12,800
Arizona	137,800	19,900	8,000	9,500	7,600	\$73,200	\$54,800	\$18,400
Colorado	95,000	13,700	5,500	6,500	6,500	\$66,700	\$54,700	\$12,000
Connecticut	42,400	6,100	2,500	2,900	2,900	\$35,200	\$8,200	\$27,100
Delaware	10,100	1,500	600	700	700	\$8,100	\$2,200	\$5,900
District of Columbia	9,600	1,400	600	700	700	\$7,300	\$1,900	\$5,300
Florida	370,800	53,500	21,600	25,500	25,500	\$261,200	\$34,000	\$227,200
Georgia	190,600	27,500	11,100	13,100	13,100	\$149,200	\$26,100	\$123,100
Hawaii	12,100	1,800	700	800	800	\$8,800	\$2,800	\$6,100
Idaho	31,400	4,500	1,800	2,200	1,600	\$19,600	\$5,200	\$14,500
Illinois	224,900	32,500	13,100	15,500	15,500	\$137,100	\$86,100	\$51,000
Indiana	118,300	17,100	6,900	8,100	7,100	\$71,100	\$25,000	\$46,100
Kansas	48,300	7,000	2,800	3,300	2,900	\$29,100	\$11,800	\$17,300
Kentucky	84,000	12,100	4,900	5,800	5,800	\$64,200	\$14,100	\$50,200
Louisiana	132,300	19,100	7,700	9,100	9,100	\$127,100	\$36,500	\$90,600
Maine	16,500	2,400	1,000	1,100	1,100	\$10,200	\$6,000	\$4,200
Maryland	88,000	12,700	5,100	6,100	6,100	\$74,800	\$25,200	\$49,600
Massachusetts	75,700	10,900	4,400	5,200	5,200	\$66,900	\$24,800	\$42,100
Michigan*	9,700	1,400	600	700	700	\$8,700	\$1,000	\$7,700
Mississippi*	4,300	600	300	300	300	\$1,800	\$800	\$900
Missouri	95,800	13,800	5,600	6,600	6,600	\$59,400	\$27,300	\$32,100
Montana	22,100	3,200	1,300	1,500	1,200	\$13,600	\$5,800	\$7,800
Nebraska	29,800	4,300	1,700	2,000	2,000	\$25,200	\$7,600	\$17,600
Nevada	60,900	8,800	3,500	4,200	3,300	\$41,900	\$20,300	\$21,600
New Hampshire	17,900	2,600	1,000	1,200	1,200	\$13,500	\$4,900	\$8,500
New Jersey	133,800	19,300	7,800	9,200	9,200	\$75,000	\$28,000	\$47,000
New Mexico*	3,900	600	200	300	300	\$2,600	\$1,300	\$1,300
North Carolina*	11,900	1,700	700	800	800	\$7,200	\$4,400	\$2,700
North Dakota	9,000	1,300	500	600	500	\$6,200	\$2,500	\$3,700
Ohio	181,600	26,200	10,600	12,500	10,900	\$113,000	\$81,700	\$31,200
Oklahoma*	6,000	900	400	400	400	\$3,700	\$1,300	\$2,300
Oregon*	5,600	800	300	400	400	\$3,100	\$1,400	\$1,700
Pennsylvania	204,700	29,500	11,900	14,100	14,100	\$68,200	\$45,200	\$23,100
Rhode Island	15,900	2,300	900	1,100	1,100	\$13,600	\$2,500	\$11,100
South Carolina*	6,000	900	300	400	400	\$4,000	\$1,800	\$2,200
South Dakota	12,800	1,900	700	900	700	\$7,500	\$2,800	\$4,600
Tennessee	78,300	11,300	4,600	5,400	5,400	\$59,000	\$20,100	\$38,900
Texas	749,800	108,200	43,600	51,600	51,600	\$572,500	\$156,000	\$416,600
Utah	40,600	5,900	2,400	2,800	2,100	\$20,500	\$6,800	\$13,700
Vermont	6,400	900	400	400	400	\$5,000	\$1,400	\$3,600
Virginia	131,100	18,900	7,600	9,000	7,800	\$73,700	\$49,900	\$23,800
West Virginia	40,400	5,800	2,300	2,800	2,500	\$30,100	\$3,500	\$26,500
Wisconsin*	4,400	600	300	300	300	\$3,000	\$600	\$2,400
Wyoming	10,700	1,500	600	700	600	\$8,000	\$6,300	\$1,700
Column sources and formulas	A8-col. 7	0.1443 * col. 1	0.403 * col. 2	0.477 * col. 2	0.477 * 0.1443 * A11-col. 8	col. 5 * A13-col. 10	col. 1 * A14-col. 6	col. 6 – col. 7

*This state has an existing expansion; these findings are estimates of the additional participation and impact that would result under the scenario.
 Note: States not included in this table have existing Medicaid family planning expansions for women with incomes up to at least the eligibility level anticipated under this scenario; the scenario would result in no new participation in these states.

TABLE 3.3. Key findings for Scenario 200 Optional, third full year

State	(1) No. of expansion participants	(2) No. of unintended pregnancies averted	(3) No. of abortions averted	(4) No. of unintended births averted	(5) No. of unintended Medicaid births averted	(6) Savings from unintended Medicaid births averted (in 000s)	(7) Spending on expansion services (in 000s)	(8) Net savings (in 000s)
U.S. total	2,599,300	375,100	151,200	178,900	174,300	\$1,762,900	\$627,900	\$1,134,900
Arizona	137,800	19,900	8,000	9,500	7,600	\$73,200	\$54,800	\$18,400
Connecticut	42,400	6,100	2,500	2,900	2,900	\$35,200	\$8,200	\$27,100
Delaware	10,100	1,500	600	700	700	\$8,100	\$2,200	\$5,900
Florida	370,800	53,500	21,600	25,500	25,500	\$261,200	\$34,000	\$227,200
Hawaii	12,100	1,800	700	800	800	\$8,800	\$2,800	\$6,100
Illinois	224,900	32,500	13,100	15,500	15,500	\$137,100	\$86,100	\$51,000
Indiana	118,300	17,100	6,900	8,100	7,100	\$71,100	\$25,000	\$46,100
Louisiana	132,300	19,100	7,700	9,100	9,100	\$127,100	\$36,500	\$90,600
Maine	16,500	2,400	1,000	1,100	1,100	\$10,200	\$6,000	\$4,200
Maryland	88,000	12,700	5,100	6,100	6,100	\$74,800	\$25,200	\$49,600
Massachusetts	75,700	10,900	4,400	5,200	5,200	\$66,900	\$24,800	\$42,100
Missouri	95,800	13,800	5,600	6,600	6,600	\$59,400	\$27,300	\$32,100
Montana	22,100	3,200	1,300	1,500	1,200	\$13,600	\$5,800	\$7,800
New Jersey	133,800	19,300	7,800	9,200	9,200	\$75,000	\$28,000	\$47,000
Pennsylvania	204,700	29,500	11,900	14,100	14,100	\$68,200	\$45,200	\$23,100
Rhode Island	15,900	2,300	900	1,100	1,100	\$13,600	\$2,500	\$11,100
Texas	749,800	108,200	43,600	51,600	51,600	\$572,500	\$156,000	\$416,600
Vermont	6,400	900	400	400	400	\$5,000	\$1,400	\$3,600
Virginia	131,100	18,900	7,600	9,000	7,800	\$73,700	\$49,900	\$23,800
Wyoming	10,700	1,500	600	700	600	\$8,000	\$6,300	\$1,700
Column sources and formulas	A8-col. 7	0.1443 * col. 1	0.403 * col. 2	0.477 * col. 2	0.477 * 0.1443 * A11-col. 8	col. 5 * A13-col. 10	col. 1 * A14-col. 6	col. 6 – col. 7

TABLE 3.4. Key findings for Scenario 250, third full year

State	(1) No. of expansion participants	(2) No. of unintended pregnancies averted	(3) No. of abortions averted	(4) No. of unintended births averted	(5) No. of unintended Medicaid births averted	(6) Savings from unintended Medicaid births averted (in 000s)	(7) Spending on expansion services (in 000s)	(8) Net savings (in 000s)
U.S. total	5,007,500	722,600	291,200	344,700	271,300	\$2,813,700	\$1,253,200	\$1,560,500
Alabama*	42,300	6,100	2,500	2,900	500	\$3,800	\$9,500	-\$5,600
Alaska	13,000	1,900	800	900	700	\$16,500	\$4,600	\$11,900
Arizona	166,700	24,100	9,700	11,500	7,600	\$73,200	\$66,300	\$6,900
Arkansas*	15,100	2,200	900	1,000	600	\$6,500	\$3,900	\$2,500
California*	188,000	27,100	10,900	12,900	7,500	\$64,200	\$38,200	\$25,900
Colorado	120,600	17,400	7,000	8,300	7,600	\$77,100	\$69,500	\$7,600
Connecticut	51,900	7,500	3,000	3,600	3,100	\$37,100	\$10,000	\$27,100
Delaware	13,200	1,900	800	900	800	\$9,500	\$2,800	\$6,700
District of Columbia	11,500	1,700	700	800	700	\$8,100	\$2,300	\$5,800
Florida	461,200	66,600	26,800	31,700	27,000	\$276,100	\$42,300	\$233,800
Georgia	243,200	35,100	14,100	16,700	15,200	\$173,000	\$33,300	\$139,600
Hawaii	15,200	2,200	900	1,000	900	\$9,300	\$3,500	\$5,900
Idaho	39,800	5,700	2,300	2,700	1,600	\$19,600	\$6,600	\$13,100
Illinois	275,700	39,800	16,000	19,000	17,500	\$155,000	\$105,500	\$49,500
Indiana	147,000	21,200	8,500	10,100	7,100	\$71,100	\$31,100	\$40,000
Iowa*	12,500	1,800	700	900	500	\$6,900	\$2,500	\$4,400
Kansas	60,900	8,800	3,500	4,200	2,900	\$29,100	\$14,900	\$14,200
Kentucky	102,600	14,800	6,000	7,100	6,100	\$67,500	\$17,200	\$50,400
Louisiana	158,400	22,900	9,200	10,900	10,100	\$141,600	\$43,700	\$97,900
Maine	20,100	2,900	1,200	1,400	1,300	\$11,400	\$7,300	\$4,200
Maryland	113,400	16,400	6,600	7,800	7,800	\$96,400	\$32,500	\$63,900
Massachusetts	91,500	13,200	5,300	6,300	5,800	\$74,900	\$30,000	\$44,900
Michigan*	44,700	6,400	2,600	3,100	1,200	\$16,000	\$4,700	\$11,400
Minnesota*	15,800	2,300	900	1,100	1,100	\$13,200	\$2,900	\$10,300
Mississippi*	19,300	2,800	1,100	1,300	500	\$3,200	\$3,600	-\$400
Missouri	120,300	17,400	7,000	8,300	7,000	\$63,000	\$34,300	\$28,700
Montana	26,600	3,800	1,500	1,800	1,200	\$13,600	\$6,900	\$6,600
Nebraska	38,400	5,500	2,200	2,600	2,200	\$26,900	\$9,800	\$17,100
Nevada	75,300	10,900	4,400	5,200	3,300	\$41,900	\$25,100	\$16,800
New Hampshire	23,700	3,400	1,400	1,600	1,300	\$14,500	\$6,500	\$8,000
New Jersey	166,700	24,100	9,700	11,500	10,500	\$85,700	\$34,900	\$50,800
New Mexico*	15,400	2,200	900	1,100	500	\$4,400	\$5,100	-\$700
New York*	79,300	11,400	4,600	5,500	3,200	\$40,500	\$20,700	\$19,800
North Carolina*	59,100	8,500	3,400	4,100	1,600	\$13,800	\$22,000	-\$8,100
North Dakota	11,100	1,600	600	800	500	\$6,200	\$3,100	\$3,100
Ohio	227,000	32,800	13,200	15,600	10,900	\$113,000	\$102,200	\$10,800
Oklahoma*	26,300	3,800	1,500	1,800	700	\$6,500	\$5,700	\$800
Oregon*	25,100	3,600	1,500	1,700	700	\$5,500	\$6,100	-\$600
Pennsylvania	252,400	36,400	14,700	17,400	14,900	\$72,000	\$55,700	\$16,300
Rhode Island	19,200	2,800	1,100	1,300	1,300	\$16,500	\$3,100	\$13,400
South Carolina*	29,200	4,200	1,700	2,000	800	\$7,700	\$8,800	-\$1,000
South Dakota	15,500	2,200	900	1,100	700	\$7,500	\$3,400	\$4,100
Tennessee	96,900	14,000	5,600	6,700	5,700	\$62,300	\$24,900	\$37,400
Texas	919,400	132,700	53,500	63,300	54,300	\$602,900	\$191,300	\$411,600
Utah	53,500	7,700	3,100	3,700	2,100	\$20,500	\$8,900	\$11,600
Vermont	8,000	1,200	500	600	500	\$5,700	\$1,700	\$4,000
Virginia	168,000	24,200	9,800	11,600	7,800	\$73,700	\$63,900	\$9,700
Washington*	25,100	3,600	1,500	1,700	400	\$5,300	\$5,500	-\$200
West Virginia	48,600	7,000	2,800	3,300	2,500	\$30,100	\$4,300	\$25,800
Wisconsin*	21,000	3,000	1,200	1,400	600	\$5,700	\$3,000	\$2,700
Wyoming	13,100	1,900	800	900	600	\$8,000	\$7,700	\$300
Column sources and formulas	A8-col. 8	0.1443 * col. 1	0.403 * col. 2	0.477 * col. 2	0.477 * 0.1443 * A11-col. 9	col. 5 * A13-col. 10	col. 1 * A14-col. 6	col. 6 – col. 7

*This state has an existing expansion; these findings are estimates of the additional participation and impact that would result under the scenario.

TABLE 3.5. Key findings for Scenario Pregnancy Care, third full year

State	(1) No. of expansion participants	(2) No. of unintended pregnancies averted	(3) No. of abortions averted	(4)/(5) No. of unintended births/ Medicaid births averted	(6) Savings from unintended Medicaid births averted (in 000s)	(7) Spending on expansion services (in 000s)	(8) Net savings (in 000s)
U.S. total	3,264,600	471,100	189,900	224,700	\$2,341,700	\$816,300	\$1,525,500
Alaska	9,200	1,300	500	600	\$14,500	\$3,300	\$11,200
Arizona	98,400	14,200	5,700	6,800	\$65,700	\$39,100	\$26,500
Colorado	95,000	13,700	5,500	6,500	\$66,700	\$54,700	\$12,000
Connecticut	39,900	5,800	2,300	2,700	\$33,200	\$7,700	\$25,500
Delaware	10,100	1,500	600	700	\$8,100	\$2,200	\$5,900
District of Columbia	9,600	1,400	600	700	\$7,300	\$1,900	\$5,300
Florida	347,100	50,100	20,200	23,900	\$244,500	\$31,800	\$212,700
Georgia	190,600	27,500	11,100	13,100	\$149,200	\$26,100	\$123,100
Hawaii	11,300	1,600	700	800	\$8,200	\$2,600	\$5,600
Idaho	19,900	2,900	1,200	1,400	\$16,800	\$3,300	\$13,600
Illinois	224,900	32,500	13,100	15,500	\$137,100	\$86,100	\$51,000
Indiana	92,800	13,400	5,400	6,400	\$63,500	\$19,600	\$43,900
Kansas	36,200	5,200	2,100	2,500	\$25,500	\$8,900	\$16,600
Kentucky	78,900	11,400	4,600	5,400	\$60,300	\$13,200	\$47,100
Louisiana	132,300	19,100	7,700	9,100	\$127,100	\$36,500	\$90,600
Maine	16,500	2,400	1,000	1,100	\$10,200	\$6,000	\$4,200
Maryland	113,400	16,400	6,600	7,800	\$96,400	\$32,500	\$63,900
Massachusetts	75,700	10,900	4,400	5,200	\$66,900	\$24,800	\$42,100
Minnesota*	23,700	3,400	1,400	1,600	\$19,900	\$4,400	\$15,400
Missouri	89,000	12,800	5,200	6,100	\$55,200	\$25,400	\$29,900
Montana	15,400	2,200	900	1,100	\$12,100	\$4,000	\$8,000
Nebraska	27,400	4,000	1,600	1,900	\$23,200	\$7,000	\$16,200
Nevada	43,200	6,200	2,500	3,000	\$37,500	\$14,400	\$23,100
New Hampshire	16,500	2,400	1,000	1,100	\$12,400	\$4,500	\$7,900
New Jersey	133,800	19,300	7,800	9,200	\$75,000	\$28,000	\$47,000
North Dakota	6,100	900	400	400	\$5,400	\$1,700	\$3,700
Ohio	140,500	20,300	8,200	9,700	\$100,300	\$63,200	\$37,000
Pennsylvania	191,900	27,700	11,200	13,200	\$64,000	\$42,300	\$21,600
Rhode Island	19,200	2,800	1,100	1,300	\$16,500	\$3,100	\$13,400
South Dakota	9,200	1,300	500	600	\$6,700	\$2,000	\$4,700
Tennessee	73,500	10,600	4,300	5,100	\$55,400	\$18,900	\$36,500
Texas	701,000	101,200	40,800	48,300	\$535,300	\$145,800	\$389,400
Utah	25,700	3,700	1,500	1,800	\$17,600	\$4,300	\$13,300
Vermont	6,400	900	400	400	\$5,000	\$1,400	\$3,600
Virginia	100,900	14,600	5,900	6,900	\$65,200	\$38,400	\$26,800
West Virginia	32,100	4,600	1,900	2,200	\$27,000	\$2,800	\$24,200
Wyoming	7,300	1,100	400	500	\$7,100	\$4,300	\$2,800
Column sources and formulas	A8-col. 9	0.1443 * col. 1	0.403 * col. 2	0.477 * col. 2	col. 5 * A13-col. 10	col. 1 * A14-col. 6	col. 6 – col. 7

*This state has an existing expansion; these findings are estimates of the additional participation and impact that would result under the scenario. *Note:* States not included in this table have existing Medicaid family planning expansions for women with incomes up to at least the eligibility level anticipated under this scenario; the scenario would result in no new participation in these states.

Chapter 4

Discussion

Over the past decade, a number of states have sought and received federal approval to expand eligibility for Medicaid-covered family planning services and supplies to individuals who otherwise would not be covered. This report has attempted to estimate the likely impact of these expansions if they were implemented on a wider scale.

The estimates developed here show that all four of the potential scenarios for expanded Medicaid eligibility would have a considerable impact in their third year of operation. The various expansions proposed in these scenarios would reduce the incidence of unintended pregnancy, abortion and unintended birth by between 12% and 25% from current levels. When looking specifically at low-income women (i.e., those with incomes less than 200% of poverty), we found that the impact would be even greater—between 20% and 39%. Moreover, by helping low-income women avoid unintended pregnancies that would otherwise result in Medicaid-funded births, these efforts would produce considerable savings for the Medicaid program: between \$1.1 billion and \$1.6 billion in Medicaid-funded pregnancy-related care during the third year of implementation.

As one would expect, giving states the option to expand eligibility without obtaining a federal waiver would have the smallest effect of all the scenarios, because not all states would be expected to take advantage of this option. Again, as one would expect, the broadest scenario—in which states are mandated to expand Medicaid-covered family planning services to all women with incomes up to 250% of poverty—would prevent the largest number of unintended pregnancies, abortions and unintended births; these outcomes would decrease by about 25% overall and by 39% among low-income women. However, because not all of the women eligible for family planning under this scenario would be eligible for Medicaid-funded pregnancy-related care if they became pregnant, this scenario has the lowest savings per dollar invested (\$2.25) among the

scenarios modeled in this project.

Either of the other two scenarios—a nationwide expansion to 200% of poverty or setting the eligibility level for family planning on par with the level for pregnancy-related care—would reduce unintended pregnancy, abortion and unintended birth in the United States by about 15% overall and by about one-quarter among low-income women. However, equalizing the eligibility levels for family planning and pregnancy-related care would be the most cost effective of the approaches considered here, because all women eligible for Medicaid-covered family planning under this approach would also be eligible for Medicaid-covered pregnancy-related care if they were to become pregnant. As a result, while this approach does not produce the largest total cost savings, it does provide the greatest savings for every dollar invested in the effort, saving an estimated \$2.87 for every dollar spent.

It must be noted, however, that these estimates assume an amount of state effort in outreach and implementation comparable to that expended by the states that have already adopted these sorts of programs. Without this level of state effort, the impact would be less. Our estimates include a 10% increase in family planning costs per user to account for the likely expense of outreach and administration.

This analysis does not address critical issues related to the capacity of the provider network to meet the demand for services under these programs. These issues are clearly key to determining the overall impact of the effort. Similarly, this analysis does not account for such national influences as the political controversy over immigration and recently adopted requirements that Medicaid recipients provide documentation that they are citizens; if such factors end up dissuading or hindering eligible women from taking advantage of Medicaid and other public programs, the impact of a family planning expansion would be reduced.

On the other hand, factors such as states' efforts at outreach and implementation, provider supply and na-

tional policy changes could also serve to increase the expansions' impact. Thus, these findings should be viewed as demonstrating the potential of Medicaid family planning eligibility expansions, rather than their definite impact.

These findings come at a particularly important moment. Between the early 1980s and the mid-1990s, women of all income groups became more likely to use contraceptives and less likely to experience unintended pregnancies. Gaps between poor women and more affluent women narrowed considerably during this period.

More recent data show a disturbing trend. Contraceptive use fell among all women from 1995 to 2002, and the drop was much larger among low-income women.³⁵ Also over that period, unintended pregnancy rates among poor women increased by 29%, even as they fell by 20% among women with higher incomes.³⁶ Today, poor women are four times as likely to experience an unintended pregnancy as are more affluent women.

Increased levels of unintended pregnancy inevitably lead to increased levels of both unintended birth and abortion. When faced with an unintended pregnancy, a low-income woman is more likely than an affluent woman to continue the pregnancy; in fact, poor women are five times as likely as more affluent women to have an unintended birth. This outcome can have serious consequences for women and their families as well as costs to society.

Abortion levels show a similar trend.³⁷ While abortion rates declined among more affluent women from 1994 to 2001, they rose among poor women. Poor women in the United States are more than three times as likely to have an abortion as are women with higher incomes.

In the midst of these disturbing trends, the data presented here suggest a roadmap for addressing this critical issue. A nationwide mandate to greatly broaden Medicaid eligibility for a discrete bundle of services is by no means unprecedented. Congress took just such a step in the 1980s to expand coverage for pregnancy-related care.

Grounded in the experience of states that have expanded eligibility for Medicaid-covered family planning services, these data show that a nationwide Medicaid expansion for family planning could greatly expand access to services and reduce unintended pregnancy. By so doing, a nationwide expansion holds out the promise of a meaningful reduction in the incidence of unintended birth; it would also lead to a reduction in abortion, a goal that should be shared by all, regardless

of their position on abortion. At the same time, the experience of states that have already expanded Medicaid coverage for family planning shows that these highly desirable goals can be achieved while saving public dollars. This combination of benefits makes similar expansions worthy of close examination by policymakers both in Washington and in state capitals around the nation.

Nonetheless, it must be acknowledged that meaningfully reducing unintended pregnancy in the United States is a goal that will not be achieved merely by increasing the availability of contraceptives. Much more needs to be understood about why people who presumably have access to contraceptive services and supplies nonetheless have difficulty in using contraceptives properly and consistently. In addition, much more attention should be paid to the constructive role that society and public policy might play in better supporting people as they try to exercise individual responsibility in their sexual and reproductive lives. Identifying and addressing these factors and obstacles, along with establishing a firm foundation of access to services for all who need them, are critically important components of a much-needed national effort to rekindle progress in reducing unintended pregnancy.

Appendix A:

Detailed Methodology and Tables

Establishing the Four Scenarios

Scenarios 200 and 250: We assume that each state would provide Medicaid family planning services to women with incomes less than 200% or 250% of the federal poverty level (FPL), respectively.* States that have existing income-based family planning expansions would raise their eligibility level, if necessary.

Scenario Pregnancy Care: We assume that each state would provide family planning services to women at the same poverty level used to determine eligibility for pregnancy-related Medicaid care as of July 2005.³⁸

Scenario 200 Optional: To gauge which states would expand coverage to women with incomes less than 200% FPL if given the option to do so without having to go through the burdensome process of obtaining a federal waiver, we made several assumptions:

- States that have already implemented expansions with eligibility ceilings lower than 200% FPL would not expand to 200%. We make this assumption because each of these states could have set their expansion's level to 200% originally but explicitly chose a lower level. These states are Alabama, Michigan, Mississippi, New Mexico, North Carolina, Oklahoma, Oregon, South Carolina and Wisconsin.
- States with more limited family planning expansions—providing several years of eligibility for women after childbirth or for anyone leaving Medicaid for any reason—would expand to 200%. In the years since they applied for these limited expansions, several studies have documented the effectiveness of the income-based approach. These states are Arizona, Delaware, Florida, Illinois, Maryland, Missouri, Rhode Island and Virginia.
- States that as of June 2006 had applications pending for an income-based expansion or that had been required by their legislature to apply for such an expansion would expand to 200%. These states are Connecticut, Indiana, Louisiana, Massachusetts, Pennsylvania and Texas.

- States that were known to have been actively exploring a waiver application or that have political environments especially favorable to family planning services expansion would expand to 200%. These states are Hawaii, Maine, Montana, New Jersey, Vermont and Wyoming.

Potential Participants Under the Expansion

Women were assumed to be potential participants for a Medicaid family planning expansion if they met all of the following criteria. They were:

- of reproductive age (13–44), although we assumed that states with existing expansions that exclude adolescents would continue to exclude them;
- in need of contraceptive services and supplies (i.e., they were sexually active, able to become pregnant, and, during all of the prior 12 months, not pregnant, postpartum or trying to become pregnant);
- eligible for the expansion on the basis of family income level (this varies by scenario), or, in the case of adolescents, on the basis of personal income (and thus all are assumed to be eligible in all scenarios); and
- uninsured for all or part of the past year (i.e., had neither private health insurance nor public health insurance such as Medicaid).

Women in Need of Family Planning Care

In 2004, there were an estimated 66 million women of reproductive age in the United States. Of these, 34 million were estimated to be in need of family planning care because they were sexually active, able to become pregnant and, during all of the prior 12 months, were

*Throughout this report, we have expressed poverty level breaks according to the rounded whole number. Thus, for example, Scenario 200 includes all women whose income is 0-199.9999% FPL. Similarly, when we report the numbers of women whose incomes fall within two values, such as 100-200% FPL or 200-250% FPL, the exact range would be approximately 100.0001% to 199.9999% or 200.0001% to 249.9999%.

not pregnant, postpartum or trying to become pregnant (Table 2.1, columns 1 and 2; and Table B1).³⁹ We used these 2004 data on women in need of contraceptive services as the basis for our estimates of potential participants, including the subgroups of women that correspond to each Medicaid expansion scenario.

The 2004 data for women in need of contraceptive services are separated into the following age and income groups:

- women aged 13–19 of all income levels; and
- women aged 20–44 by three poverty groups (<100% FPL, 100–250% FPL, ≥250% FPL).

To estimate the numbers of women who would be potential participants under each Medicaid expansion scenario, we regrouped women according to the specified age and poverty breaks relevant for Medicaid family planning coverage under each scenario (Table 2.1, columns 3–6). Information from two additional sources was necessary in order to categorize women appropriately. First, similar data on women needing contraceptive services and supplies in 2002 were available that provided greater detail on the distribution of women by age and poverty level than did the 2004 data (Tables A1 and B2)⁴⁰; second, we tabulated data from the Current Population Survey (CPS) to estimate the distribution of 19-year-olds by poverty status (Table B3).⁴¹ Our specific calculations for adolescents and for adult women by poverty are detailed below.

Separating 18- and 19-year-olds (Table A1). Women aged 19 are considered adults for purposes of Medicaid; only teenagers aged 18 or younger are considered adolescents. This is important because we assume that for family planning coverage, adolescents are enrolled on the basis of their own income and not that of their parents. Because few adolescents have significant sources of personal income, we assume that income level is not a factor in determining whether adolescents would be potential participants in Medicaid family planning coverage.

We estimated the number of 19-year-olds in 2004 who were in need of contraceptive services in each state based on the age distribution of similar women in 2002. The 2002 data for adolescents were divided between two age groups, 13–17 and 18–19; within the later group, we assumed that 18- and 19-year-olds were distributed uniformly. The formula used was:

- No. of 19-year-olds in 2004 = (No. 13–19-year-olds in 2004) × [(1/2 (No. of 18–19-year-olds in 2002)) ÷ (No. of 13–19-year-olds in 2002)]

This formula was applied to data for each individual state. The estimated number of 19-year-olds in each state was then subtracted from the number of women aged 13–19 to obtain the number of 13–18-year-olds of all income levels. Nineteen-year-old women were added to women aged 20–44 according to their expected poverty status (see below).

Separating adult women by poverty level (Tables A2–A4). To obtain the exact number of adult women at different poverty levels in 2004 in each state, we used the more detailed poverty information available for 2002 and interpolation between some poverty breaks not available in either year. (The poverty breaks available for 2002 were <100% FPL, 100–133% FPL, 133–185% FPL, 185–250% FPL and ≥ 250% FPL.) Additional tabulations were needed to estimate the poverty level of 19-year-olds.

For Scenarios 200 and 200 Optional (Table 2.1, column 4; and Table A2), we used the actual number of women with incomes less than 100% FPL in 2004 in the state; we then estimated the number of women with incomes between 100% and 200% FPL by calculating the proportion of women 100–250% FPL in 2002 who were between 100–200% FPL and multiplying that percentage by the number of women 100–250% FPL in 2004 (Table A2, columns 1–8). For more detailed poverty breaks within these larger categories, we estimated the proportion and number pro rata, assuming uniform distribution within the broader intervals. For example, to estimate the percentage of women whose incomes fell between 185% and 200% FPL, we calculated it as $(200 - 185) \div (250 - 185)$, or 23% of all women between 185% and 250% FPL.

We estimated the number of 19-year-olds with incomes less than 200% FPL by using the distribution of women aged 20–24 by poverty level within each state tabulated from the 2003–2005 CPS (Table B3) and assuming that this distribution applied to 19-year-olds. (Note that here and elsewhere in our calculations, we combined CPS data from three years to increase the stability and reliability of our estimates.) The total number of 19-year-olds in each state (Table A1, column 7) was multiplied by the proportion of women aged 20–24 in the state who were less than 200% FPL (Table B3, columns 1 and 2) to get women aged 19 less than 200% FPL (Table A2, column 9). We then added this figure to the corresponding number of adult women less than 200% FPL to obtain the total estimated number of adult women in need of family planning (Table A2, column 10).

For Scenario 250 (Table 2.1, column 5; and Table A3), we summed the actual number of women aged 20–44 with incomes less than 250% FPL in 2004 with an estimated number of 19-year-olds less than 250% FPL. The latter was calculated by multiplying the total number of 19-year-olds in the state with the proportion of women aged 20–24 in the state who were less than 100% FPL plus the proportion who were between 100% and 200% FPL inflated by a factor of 1.5 (Table A3, columns 3–6).

For Scenario Pregnancy Care (Table 2.1, column 6; and Table A4), we estimated the number of potential participants in each state using the current eligibility level for pregnancy care in the state. We assumed that women with incomes between 100% and 200% FPL were distributed uniformly,* and applied the following formulas to the estimated number of women between 100% and 200% FPL in 2004 calculated for Scenario 200 (Table A4):

- No. of women 100–133% FPL in 2004 = No. of women 100–200% FPL in 2004 \times 0.33;
- No. of women 100–150% FPL in 2004 = No. of women 100–200% FPL in 2004 \times 0.50;
- No. of women 100–175% FPL in 2004 = No. of women 100–200% FPL in 2004 \times 0.75;
- No. of women 100–185% FPL in 2004 = No. of women 100–200% FPL in 2004 \times 0.85;
- No. of women 100–250% FPL in 2004 = No. of women 100–250% FPL in 2004; and
- No. of women 100–275% FPL in 2004 = No. of women 100–250% FPL in 2004 + 1/2 (No. of women 200–250% FPL).

Insurance Coverage for Women in Need

Although Medicaid coverage is not prohibited among women who have private health insurance, we expect that the majority of potential participants for expanded Medicaid family planning coverage will come from the ranks of uninsured women. Moreover, because insurance levels vary considerably among states, we felt it was important to include an adjustment for insurance status when estimating state-level differences in participation.

For this calculation, we multiplied our estimates of in-need adolescents and in-need, income-eligible adult women by estimates of the percentage among each group who were uninsured during the prior year to obtain estimates of the total number of potential participants in an expansion under each scenario (Table 2.2, columns 3–5). We used combined CPS data for March 2003, 2004 and 2005 to make state-level estimates of

the proportions of women who were uninsured.⁴² Separate tabulations were done for women aged 13–18 (Table B4) and for women aged 19–44 with incomes less than 200% FPL (Table B5). Two separate adjustments were made for these data (Table A5).

Adjustment for insurance status among women in need.

The estimates from the CPS are available only for all women of reproductive age, a group that is larger than women in need of contraceptive services and supplies, because it also includes women who are unable to become pregnant, as well as those who are pregnant or trying to become pregnant. Using the National Survey of Family Growth (NSFG), we tested whether or not the insurance status of women in need of contraception differs from that of all women.⁴³ For adult women, the differences were extremely small and no adjustment was needed. For adolescents aged 15–18, however, the proportion who were uninsured was higher among those in need than among all adolescents, so we calculated an adjustment factor.

Nationally, the percentage of 15–18-year-old women who were uninsured in the NSFG was 9.6%. The percent of adolescents in need who were uninsured in the NSFG was 11.7%. We calculated the percent difference between these two numbers as $(11.7 - 9.6) \div 9.6 = 0.22$ and inflated the percent of all adolescent women who were uninsured in each state (from the CPS) by 22% to estimate the percentage of adolescents in need who were uninsured (Table A5, column 2). This adjustment was calculated at the national level and the same factor was used for each state.

Adjustment for uninsured status at any time during the year. The estimated proportions of uninsured women in the CPS likely undercount women who might be potential participants in an expanded Medicaid program because they do not account for women who may have been insured during only a portion of the year. In addition, although the CPS is designed to measure insurance status over the entire past year, the proportions of people reporting that they were uninsured all year look more like the point-in-time estimates derived from other national survey data, and many analysts hypothesize that CPS respondents may be, instead, reporting their current insurance status.⁴⁴ To adjust these proportions, we looked at national patterns of insurance

*We used the more detailed poverty data for 2002 to examine the distribution of women between 100% and 250% FPL in 2002 at the national level. In general, we found women to be fairly uniformly distributed within this group.

coverage drawn from the NSFG and calculated an inflation factor.

We used the 2002 NSFG to calculate the national percentage of women who were currently uninsured and the percentage uninsured at any point during the year (for adolescents aged 15–18 and women aged 19–44 whose incomes were less than 200% FPL) and used the difference between these two percentages to calculate an adjustment factor that could be applied to the CPS state-level percentages of women uninsured.⁴⁵ We decided to use the NSFG percent currently uninsured, rather than the percent uninsured all year, because it appears to more closely approximate the values obtained from the CPS, and it produces a more conservative estimate of the adjustment factor. For adult women with incomes less than 200% FPL, 27.2% were currently uninsured nationwide and 42% were uninsured at some time during the year (19.9% reported being uninsured during all of the prior year). Thus, the adjustment was calculated as $(42.0 - 27.2) \div 27.2 = 0.54$. We applied this adjustment to each state by inflating the percentage of uninsured adult women with incomes less than 200% FPL from the CPS by 54% (Table A5, column 6).

Of adolescents aged 15–18, 11.7% were currently uninsured and 21.4% were uninsured at some time during the year. Thus, for adolescents the adjustment was calculated as $(21.4 - 11.7) \div 11.7 = 0.83$. This was applied to each state by inflating the percentage of uninsured adolescents from the CPS by 83%. Again, because these adjustments were calculated at the national level, the same factors were used for each state (Table A5, column 3).

Note that our estimates of potential participants in a family planning expansion may include some women who were uninsured but who could have qualified for and enrolled in regular Medicaid. To the extent that states' implementation of a family planning expansion succeeds in attracting additional women to regular Medicaid instead, we are giving credit to the expansion for pregnancies averted by (and family planning costs incurred by) these new Medicaid recipients. This phenomenon is to be expected and has been seen previously, for instance, in states' implementation of the State Children's Health Insurance Program in the late 1990s.⁴⁶

Also worth noting is that we initially estimated the number of potential participants in the program without making the adjustment to reflect women who were uninsured at any point during the year. We found that this produced estimates that were clearly too low: The

number of women actually using services in existing family planning expansions was typically higher than the number estimated to be potential participants—in several cases, twice as high. Even the current estimate appears to be something of an undercount, given that three of the states with existing expansions have reached or exceeded 100% of our estimated number of potential participants. For logistical reasons, we can expect that a program would never reach 100% of its true potential.

Women Who Would Use Services

To estimate the number of potential participants in an expansion who would actually use family planning services, we relied on the experience of the states that have already implemented Medicaid family planning expansions. Of the 15 states that had approved income-based expansions, eight states (Alabama, Arkansas, California, New Mexico, Oregon, South Carolina, Washington and Wisconsin) had data available from program evaluations on the number of women who had used contraceptive services under their program.⁴⁷

First, we estimated the number of potential participants in each of the existing expansions. To do so, we followed the same methodology described above, estimating the number of in-need, uninsured women aged 13–44 whose incomes fell below the eligibility level for each state's family planning expansion (Table A6, columns 1–8). Two of the states, Alabama and New Mexico, restricted their expansions to women aged 19 and older; for these states, the estimates of potential participants exclude adolescents.

Next, we divided the actual number of users a given state reported for the first full year of data collection and the third full year of data (Table A7, columns 4 and 5) by the number of estimated potential participants in that state. That created a rate of use among potential participants for each state in each year (Table A7, columns 6 and 7).

We focused on the third full year of data availability from each state's expansion to standardize the rates of use by the stage of program implementation. We expected programs to take several years to approach their full potential. (In fact, several existing expansions have continued to grow through their fifth or sixth year.)

The final step in determining use among potential participants was to average the rates of use in the third year for states with data available. We excluded the rates from New Mexico from this calculation because they were very low outliers. Two other states did not have data for the third year. Among the five remaining

states, the average rate of use for the third year was 83.45%.

These average rates of use among potential participants were then applied to all of our scenarios. For states without existing expansions, we multiplied the estimated number of potential participants in an expansion under each scenario by the average rate for the third year (Table A8, columns 7–9). For states where a given scenario would expand coverage beyond what currently exists, we applied the rates of use only to the number of new potential participants, subtracting the numbers estimated to already be potential participants in the state’s expansion program (Table A6, column 8; and Table A8, columns 4–6). For states where the scenario would not expand coverage, no new users were counted.

In addition to the figures for the third year, we calculated two other sets of projections for program participation. First, to provide some guidance for what a program may look like early in its development, we calculated rates of use for the first full year of available data, as noted above. Again excluding New Mexico, this rate averaged 60.22% for the remaining seven states. Second, noting that three states by the fifth or sixth year of an existing expansion reached or exceeded 100% of our estimated number of potential participants, we also calculated numbers of users at 100% use.

It is important to note that these estimated rates of use are based on a comparison of the number of real expansion participants with the number of estimated potential participants. The fact that three states reached 100% of this potential implies that we are likely undercounting the number of potential participants and therefore overstating what would be real-life rates of use. For example, it is likely that some number of insured women are participating in the existing expansions (e.g., for privacy reasons or to avoid copayments) and would participate in any future expansion programs. Some women older than 44 may also be participating. Because such women are included in the numerator of the calculation for rate of use (i.e., the number of actual participants in existing expansions), the resulting ratio may appear high. Yet this rate of use will accurately predict the number of participants in future expansions, even if such women are not included in the denominator (i.e., the number of potential participants), because the comparison of actual to potential participants is being made consistently across all states. Moreover, by excluding insured women from our denominator, we are able to account more accu-

rately for state-by-state variation in insurance status, a characteristic that we believe to be central to the likelihood of women’s participation.

Another important caveat is that it is likely that states, in practice, will experience some degree of variation in the rate of use among potential participants. Using data from a limited pool of existing expansions, we cannot predict this variation. However, the states upon which we based our national estimate vary in important characteristics (e.g., size, region and political climate). Despite these differences, their rates of use are quite similar (excluding the outlier, New Mexico): The five states used to generate the average rate of use during the third full year had rates ranging from 72% to 94%. If we had looked at this rate of use among other types of Medicaid expansions, including the more limited family planning expansions, we would have expected much greater variation than among these income-based family planning expansions. Considering that all four of our scenarios are similar in scope and narrowly focused in their purpose, a single average rate, although not ideal, can be expected to provide reasonable estimates of participation.

Contraceptive Use Among Program Participants

To estimate the increase in contraceptive use and in the use of highly effective methods among expansion participants, we compared the contraceptive behavior of potential participants prior to their participation in the waiver program with the contraceptive behavior that would be expected of them after they join the expansion. This methodology allows us to measure the added impact of the program by accounting for the fact that some users will be substituting care paid for by Medicaid under the expansion program for care that they had received from other publicly funded sources or that they had paid for out of pocket.

We used the 2002 NSFG to examine the contraceptive method mix of two populations of women that, in our estimation, best represent women before and after joining an expansion (note that these populations have some overlap):⁴⁸

- The method use of potential participants before the expansion was represented by women in the NSFG who met the characteristics of potential participants described earlier (i.e., income- and age-eligible women who were sexually active, able to get pregnant and not currently pregnant, postpartum or seeking pregnancy, and who were uninsured for some period in the prior year), regardless of current method use or use of public services

(Table A9, columns 2 and 3).

- The expected method use of these women after joining the expansion was represented by women in the NSFG who reported receiving one or more contraceptive services from a publicly funded provider (including women who received care from publicly funded family planning clinics as well as those who received Medicaid-funded contraceptive care from private providers) during the prior 12 months and were current reversible contraceptive users or had received a publicly funded tubal sterilization in the prior year (Table A9, columns 4 and 5).

We assumed that the subset of potential participants who would actually use the expanded services should they become available would have the same initial contraceptive method mix as the total group of potential participants in the program. Given the high percentage of potential participants expected to actually participate, this assumption is quite reasonable, and we have no reason to believe that those who end up not participating are either more or less likely to be using more or less effective contraceptive methods prior to implementation than those who do participate. In addition, we assumed that all women who participate in the program would become contraceptive users and would have the contraceptive method mix of method users currently relying on publicly funded providers.* Our assumption that all participants will adopt a method differs from the experiences of some current programs (e.g., California's Family PACT program), which report serving a number of clients who do not adopt a contraceptive method. We suspect that this is due to the fact that these programs often include a range of services beyond those considered to be family planning services under Medicaid and that some clients are served who only need the non-family planning services offered by the program. Because the scope of the

*Although the method mix expected for women after joining the program was based on current use among women attending clinics and women obtaining Medicaid-funded care from private providers, those attending clinics were by far the majority of this group. To assess if the method mix (and resulting level of effectiveness) might be different if higher percentages of expansion participants began receiving Medicaid-funded care from private doctors, we compared the current method mix of women who made recent visits to clinics to that of women using private doctors. Although the mix of methods was somewhat different, the provision of hormonal versus barrier methods was similar (e.g., a higher percentage of women going to clinics received Depo-Provera, whereas more women going to private doctors received oral contraceptives); we expect that overall the methods obtained from different provider types would result in similar effectiveness levels.

program being designed here only includes family planning care reimbursed by Medicaid at the 90% rate, it is unlikely that many participants would receive family planning care without being provided with a contraceptive method.

One way of comparing the relative level of protection provided by the distribution of methods used by each population is to calculate a contraceptive protection index. This index essentially is an average of all failure rates (expressed in their inverse, or $100 - \text{the failure rate}$) weighted by the proportion of women using each method. Potential participants before joining the program are estimated to have a contraceptive protection index of 71.6, whereas after joining the program and adopting more effective methods, they are expected to have an index of 91.9.

Given the contraceptive behavior of these two populations, we used a previously developed methodology to estimate the number of unintended pregnancies that would be expected under each situation.⁴⁹ One advantage of this methodology is its ability to accurately assess variation among different populations of women, because it is able to account for behavioral differences in contraceptive use and contraceptive failure among subgroups of women defined according to age (15–19, 20–24, 25–29 and ≥ 30); race (black and non-black); marital status (married, cohabiting and not in union); and poverty status (incomes $< 100\%$ FPL, $100\text{--}200\%$ FPL and $\geq 200\%$ FPL). Calculation of expected unintended pregnancies is then based on the method-mix distribution for each subgroup of women (potentially 72 subgroups).

Pregnancies, Abortions and Births Averted

To estimate the number of unintended pregnancies averted by the Medicaid family planning expansions, we calculated the expected numbers of unintended pregnancies that would occur to our hypothetical populations of women before and after implementation of a Medicaid family planning expansion.⁵⁰ Key to these calculations is the application of subgroup-specific contraceptive failure rates to the appropriate subgroups of women using each method in either the before or after population.

Contraceptive Failure Rates

To estimate the proportion of women in each subgroup who would be expected to experience an unintended pregnancy, we began with one-year contraceptive failure rates for subgroups defined by age, marital status and poverty (Table B6) estimated in 1999.⁵¹ (The

method-specific failure rates for the entire population are presented in Table A9, column 1, for purposes of illustration.) However, these one-year failure rates cannot accurately predict the number of unintended pregnancies that would actually occur to a population of women using each method at a particular point in time: Some women will not have used the method for the entire 12 months (and therefore are exposed for shorter periods of time); others may have used their method for much longer than one year, and their failure rates would be expected to be much lower. Therefore, we calculated a discount factor that would accurately adjust for these situations and result in expected numbers of unintended pregnancies that are in line with the actual numbers of unintended pregnancies occurring among U.S. women.

Adjustment of method use failure rates. To calculate this adjustment factor, we compared the actual number of unintended pregnancies that occurred to U.S. women using reversible contraceptive methods in a one-year period with the expected number of unintended pregnancies calculated by applying subgroup-specific one-year contraceptive failure rates to the total population of U.S. women using reversible contraceptives (broken into appropriate subgroups). Specifically, in 2001, of the 3.1 million unintended pregnancies that occurred, 1.5 million were to women who reported using a reversible contraceptive method during the month of conception.⁵² In the same year, 24.3 million U.S. women reported use of reversible contraceptive methods at the time of the NSFG. Applying the subgroup-specific failure rates to these 24.3 million women results in an expected 2.5 million unintended pregnancies to users of reversible methods (if we assume use over a one-year period and first-year failure rates). Therefore, in order to use a point-in-time distribution of women by method use to accurately predict expected unintended pregnancies over a one-year period, it is necessary to discount our one-year failure rates by 59.84%.* This discount factor was then applied to each subgroup-specific one-year failure rate prior to calculation of the expected unintended pregnancies before and after program implementation.

Adjustment of nonuse failure rates. A separate calculation was made to adjust the number of unintended pregnancies that would be expected to women who did not use any method. We began with age-specific expected failure rates for no method use that vary around the average failure rate for no method (85%) but take

into account expected fecundity differences among women in different age groups.⁵³ Then, similar to the methodology employed in adjusting failure rates for reversible methods, we compared the actual number of unintended pregnancies that occurred to U.S. women who were using no method with the expected number of unintended pregnancies that would occur to women currently using no method if they continued to be nonusers all year. Here the differences between actual and expected unintended pregnancies are even more extreme. In 2001, 1.6 million unintended pregnancies occurred to women who were using no method in the month they conceived. In contrast, 4.6 million women in the NSFG were current nonusers who were at risk for unintended pregnancy, and applying age-specific nonuse failure rates to these women would result in an expected 4.0 million unintended pregnancies. Thus, the overall adjustment that would be necessary to account for differences in the actual versus the expected number of unintended pregnancies during one year to all women who were nonusers at some point in time would be 40%.

However, this average adjustment cannot be assumed to apply to all nonusers equally, and we expect that real differences in nonuse failure rates will vary according to women's likelihood of participation in a Medicaid family planning expansion. There are several reasons that actual and expected unintended pregnancies to nonusers are so different, including length of exposure to nonuse (periods of nonuse are typically shorter than one year); frequency of sexual activity (nonuse failure rates of 85% assume frequent exposure through regular sexual activity); and women's fecundity (even if fecund, some women have difficulty getting pregnant, and their nonuse may be related to knowing that a pregnancy is unlikely to occur). Nonusers who have infrequent sexual activity or know that it may be difficult for them to conceive are probably less likely to seek out family planning services under a Medicaid expansion than are those nonusers who would be likely to become pregnant if they remained nonusers or who may have had a recent unintended pregnancy while they were using no method.

Therefore, in order to determine an adjustment factor that would be appropriate for this analysis, we attempted to measure how much of the difference between expected and actual unintended pregnancies among nonusers could be attributed to length of expo-

*This figure was calculated as follows: 1,513,238 actual unintended pregnancies to reversible contraceptive users divided by 2,528,597 expected unintended pregnancies based on one-year failure rates = 0.5984.

sure to nonuse and how much was likely due to reduced frequency of sexual activity or decreased fecundity among nonusers. Using national data on average lengths of nonuse over a one-year period, we estimated that, overall, women's exposure to nonuse equaled only 77% of the total time that would be expected if all current nonusers remained nonusers for an entire year. Thus, we expect that the remainder of the difference between expected and actual unintended pregnancies to nonusers can be attributed to nonusers who have a reduced likelihood of experiencing contraceptive failure due to decreased levels of sexual activity or fecundity. Here we assume that those women who are nonusers prior to joining the program (21.5% of potential participants) should have nonuse failure rates that are adjusted to account for the likelihood that, for part of the year, they either used contraceptives or were not sexually active. Yet because they are seeking family planning services, we assume that their fecundity and frequency of sexual activity are similar to those of other women already using services and that their nonuse failure rates should not be adjusted to account for decreased levels of sexual activity or fecundity. We therefore applied the adjustment of 77% to our age-specific failure rates for nonuse prior to calculation of expected unintended pregnancies.

Estimating Unintended Pregnancies Averted

Unintended pregnancies prior to program implementation. We calculated the expected number of unintended pregnancies that would occur to potential participants if the program were not implemented by applying the discounted contraceptive and nonuse failure rates to the subgroup-specific distribution of methods used by potential participants. Among our hypothetical sample of 4.5 million eligible NSFG respondents, current preprogram contraceptive use would result in 1,014,000 unintended pregnancies (Table A9).

Unintended pregnancies after program implementation. We calculated the expected number of unintended pregnancies to women after program implementation by applying the subgroup-specific method mix of women currently using publicly funded services to the subgroup-specific numbers of women in our population of potential participants and then multiplying the new number of women using each method (in each subgroup) by the discounted subgroup-specific failure rate for the method. Based on this new method mix, our hypothetical sample of 4.5 million women would be

expected to experience 366,000 unintended pregnancies after program implementation.

Unintended pregnancies averted. Subtracting the unintended pregnancies expected after implementation from those expected prior to the program, we projected 648,000 unintended pregnancies averted among our hypothetical national NSFG sample of participants in the program. On this basis, we calculated the number of pregnancies averted per user that could be applied to each of our scenarios to estimate how many pregnancies would be averted, given various numbers of expected users: pregnancies averted ratio = 648,000 pregnancies averted ÷ 4,491,000 women = 0.1443, or an estimated 144.3 unintended pregnancies prevented for every 1,000 women participating in the program. We applied this same national ratio to the numbers of expected users in each state under each scenario to estimate total unintended pregnancies averted.

At this point, it is important to reemphasize that we are estimating only the added benefit of an expanded Medicaid program. We are not measuring unintended pregnancies that would have been prevented by all contraceptive use among program participants—including use of contraceptives that some women would have obtained regardless of the program. In comparison, if all potential participants were assumed to have used no method prior to program implementation, the number of unintended pregnancies prevented would have been over four times greater.

Distribution of unintended pregnancies by outcome. We then applied the national distribution of unintended pregnancies by outcome among women with incomes less than 200% FPL⁵⁴ to our findings to estimate the numbers of abortions and unintended births that would be prevented:

- percentage of unintended pregnancies resulting in abortions = 40.3%; and
- percentage of unintended pregnancies resulting in births = 47.7%.

The remaining unintended pregnancies result in spontaneous pregnancy losses.

Medicaid Births Averted

For Scenarios 200, 200 Optional and 250, we accounted for the fact that not all averted unintended births in those scenarios would be paid for by Medicaid. The cost of averted unintended births to women with incomes above the eligibility ceiling for pregnancy-related Medicaid coverage cannot be considered sav-

ings for the federal or state governments.

In order to address this problem, we created additional estimates of the number of potential participants in an expansion who would also be eligible for pregnancy-related care under Medicaid for each of the three scenarios (Tables A10 and A11). These estimates followed the same procedure used when estimating the number of potential participants in an expansion under Scenario Pregnancy Care.

However, these numbers were adjusted upwards to account for another complication: Pregnant women are counted as two people in weighing whether their income is low enough to qualify them for Medicaid. This impact of the pregnancy on poverty-level status varies according to the size of the family: The smaller the family size, the larger the effect. To be conservative, we based our adjustment on an average family size of five (without the fetus). The poverty level was \$25,210 for a family of six, and \$22,030 for a family of five in 2004, the year of our data on expansion participants,⁵⁵ so the inflation factor was calculated as $25,210 \div 22,030 = 1.14$. For example, if a state's eligibility ceiling for pregnancy-related care was 133% FPL, a nonpregnant woman would be potentially eligible for such care at $133\% \times 1.14 = 152\%$ FPL (Table A10, column 5). The eligibility level was capped at the maximum level of the scenario (200% FPL or 250% FPL).

For states without an existing waiver program, the number of family planning participants also eligible for pregnancy care was taken directly from this calculation (Table A11, columns 8 and 9). For states with existing waivers, we subtracted the number of potential participants with incomes lower than the existing waiver's eligibility level (Table A6, column 8; and Table A11, columns 6 and 7) before calculating the number of estimated participants. From these figures, we followed the procedures from earlier steps to calculate the number of unintended births averted to women eligible for Medicaid-covered pregnancy-related care.

Cost of Medicaid Births

Available data did not allow us to directly estimate the cost per Medicaid birth in each state. Instead, we relied on data from 22 states culled from their applications for and evaluations of Medicaid family planning expansions (Tables A12 and A13).⁵⁶ These data include costs under Medicaid for prenatal care, delivery, postpartum care and one year of medical care for the infant.

We used the existing data to make estimates for the remaining 28 states and the District of Columbia. This involved a series of adjustments to reflect geographi-

cal differences in costs, as well as differences in when the original data were collected.

First, we adjusted the existing data—which were collected in various states between 2000 and 2005—to reflect 2005 dollars, using the Consumer Price Index, Urban, for medical services (Table A12, columns 3–6).⁵⁷

Next, we applied two indices of relative costs to adjust for both fee-for-service (FFS) and capitated plans:

- an index of states' physician fees under FFS Medicaid (developed by researchers at The Urban Institute and the Center for Studying Health System Change);*⁵⁸ and
- an index of estimated statewide Medicaid capitation rates (developed by researchers at The Urban Institute).^{†59}

The index of physician fees was available for 49 states and the District of Columbia. The index of Medicaid capitation rates was available for 35 states and the District of Columbia—all but three of the states that made use of capitated plans under Medicaid in 2001, when the index was created. The second index was necessary for evaluating costs per birth because Medicaid services for pregnancy-related care are often covered by capitated plans, and costs may vary considerably between FFS and capitated plans.

For states where both indices were available, we created a composite FFS and capitated managed care index that was based on the proportion of the states' Medicaid enrollees in each type of plan (Table A13, columns 2 and 5–7).⁶⁰ We applied this composite index to the existing data and found an average of the adjusted data (Table A13, column 8). Then we applied the composite index to the average to make estimates for the relevant states (18 states and the District of Columbia; Table A13, column 9). For states without capitation (and in one case, Nebraska, where the state did have capitated plans but did not participate in the study

*The researchers collected 2003 data on physician fees for a variety of services from the 49 states and the District of Columbia that had a fee-for-service component in their Medicaid program. To combine data on individual fees from different states into a broader index, they constructed weights to reflect the relative importance of each service (on the basis of spending) and each state (on the basis of number of beneficiaries).

†The researchers collected 2001 data on Medicaid managed care payment methods and capitation rates for children and parents from 35 states and the District of Columbia. They then constructed standardized capitation rates for each state, accounting for differences in age, sex, treatment of maternity expenses, covered and carved-out benefits and other factors. We converted the adjusted capitation rates into an index by dividing each state's rate by the national average.

that produced the Medicaid capitation index), we performed a similar calculation using only the index of physician fees (nine states; Table A13, columns 3 and 4). Tennessee was missing from both indices; instead, we used the national average.

The final national average came to \$10,948 per birth (Table A13, column 10). We multiplied the number of unintended Medicaid births averted by each state's cost per birth to arrive at savings from Medicaid births averted under each scenario.

We do not include any government savings from averted abortions in our estimates. Only a minority of states (17 as of June 2006) have a policy to provide public funding for medically necessary abortions for Medicaid-eligible women.⁶¹ The remaining states typically follow the federal policy of providing funding only in cases of rape, incest or when the woman's life is endangered by the pregnancy. As a result, states spent \$72 million on abortions in FY 2001 (the latest year for which data are available), and only \$11 million of that was in states that had not yet implemented an income-based family planning expansion.⁶² Even if new expansions under our scenarios were to avert a large portion of that \$11 million, the savings would be much less than 1% of the gross savings from averted births, small enough to be insignificant to our estimates.

Cost of the Family Planning Expansion

To estimate the cost per participant if states were to provide family planning under a Medicaid expansion, we drew primarily on the Medicaid Statistical Information System (MSIS),⁶³ under which states periodically submit data on eligibility and claims for Medicaid clients. We used 2003 data for all 50 states and the District of Columbia on two items (Table A14, columns 1 and 2):

- total Medicaid dollars paid for FFS family planning services; and
- total beneficiaries who received any FFS family planning services during the year.

We limited the data to women aged 13–44. From these data, we calculated spending per beneficiary under the FFS portion of Medicaid (Table A14, column 3). We deemed this a reasonable estimate for spending per user under a family planning expansion. Note that family planning services include all services and supplies claimed by the state at the special 90% rate of federal reimbursement for family planning (see Introduction) and do not include other services that family planning clients may have received during a family

planning visit that would not be considered family planning or reimbursed at the 90% rate.

In exploring the data, we saw some potentially troubling outliers and extremely small numbers of Medicaid family planning users in certain states. We suspected, for example, that in a few states that rely heavily on capitated managed care, the FFS data were not representative of a typical beneficiary in the state. Therefore, we used additional MSIS data to look at a number of factors to help us identify states for which data should be replaced with an estimate. The main issues we looked at were:

- the proportion of overall Medicaid spending and beneficiaries in capitated managed care;
- the proportion of overall FFS spending for, and beneficiaries using, family planning;
- how the MSIS estimates of per capita spending compared with estimates used by states in applying for and evaluating the existing Medicaid expansions; and
- the consistency of the MSIS data over time, on the basis of data available from four prior years.

Ultimately, we identified five jurisdictions (Arizona, the District of Columbia, Rhode Island, South Carolina and Tennessee) for which we rejected the MSIS data as unrepresentative. Four of these jurisdictions relied extremely heavily on capitated managed care, and there was very little FFS family planning use, a situation that led to large fluctuations in the data over time. The fact that South Carolina reported what seemed to be an exorbitant amount of family planning spending (11.5% of all Medicaid spending) led us to question the accuracy of the reporting.

For these five jurisdictions, we estimated the cost per user of family planning services by taking the national average for the remaining states and adjusting it for state-level variation in medical costs. To do so, we used the index of states' relative physician fees under the FFS portion of Medicaid (Table A14, columns 4 and 5). As for costs per birth, we used the unadjusted national average for Tennessee, the only state not to participate in the study that produced this index.

We then needed to adjust these costs per user, which were from 2003, to reflect 2005 dollars, using the Consumer Price Index, Urban, for medical services (Table A14, column 6). Finally, we inflated each state's costs per user by 10% to account for outreach, administrative and other expenses in implementing a program that would not be captured by the MSIS data on family planning services (Table A14, column 7). We chose 10% as

a conservatively high estimate because it is the maximum amount that states can spend on administrative costs, including outreach, under the State Children’s Health Insurance Program, a sister program to Medicaid also administered by CMS. Notably, the rough estimates of outreach and other administrative costs provided by states in their family planning waiver applications—and those reported in program evaluations that include such data—have been considerably lower than 10% of program costs. The final national average was \$257 annually spent per family planning user.

Note that the estimates for states without cost data are based on the unweighted average of the remaining states’ costs per user; if a weighted average had been used, that average would have been \$232 in 2005 dollars. We chose to use unweighted averages because states’ reimbursement rates vary considerably and there was no reason to think that the estimates should specifically reflect the rates and spending in the most populous states.

Also of note is the fact that with a few exceptions, the estimates of family planning costs per user cited in states’ waiver applications are higher than the estimates used here (on average, about 20% higher). One thing that may explain most or all of this discrepancy is that the waiver programs all cover services beyond those considered “family planning” by CMS—services that are not claimed at the special 90% matching rate and are, therefore, not included in the MSIS estimates. Because the scope of this additional spending varies substantially among existing programs and because we cannot predict how states will implement new expansions under each of our scenarios, we cannot account for this likely additional spending. The additional services include treatment for STDs, screenings and referrals for other health problems, and other preventive services. Such services, in theory, generate additional savings for the government that are unrelated to preventing unintended pregnancy. These costs and savings—as well as any incurred by states that decide to provide services to men under an expansion—are beyond the scope of this study.

The last step in estimating total program costs was to multiply the number of expansion participants under each scenario by each state’s family planning cost per user.

Net Savings from the Expansion

The final step in our study was to subtract the family planning program costs from the savings produced by averting unintended Medicaid births. The result is the

net savings from the expansion for each state under each scenario.

National-level estimates of dollars saved per dollar spent were calculated by dividing total savings by total costs. We do not present comparable state-level findings. Because we used a nationwide estimate of pregnancies averted per expansion participant, variations at the state level in savings per dollar spent would reflect differences in costs and reimbursement rates for family planning and births. Where they reflect real differences in costs, these data may point to states that would benefit most from an expansion. Where they reflect differences in reimbursement rates, however, these data may point to potential problems in attracting family planning providers to a Medicaid expansion—problems that could greatly hinder an expansion in preventing unintended pregnancies, abortions and unintended births. Unfortunately, we do not have sufficient data to make this distinction. Rather, policymakers, advocates and providers in each state are better positioned to gauge their own state’s situation.

Additional Projections

Several additional projections are included in the appendix tables.

First full year and 100% use. We calculated the number of potential participants and impact (pregnancies averted and cost savings) for the first full year of use (as opposed to our main calculations, which are for the third year of use) and 100% participation among potential participants of a Medicaid family planning expansion program under each scenario (Tables A15–A22).

Costs and savings to state and federal governments. In addition, we present the costs and savings for the third full year of use under each scenario apportioned to the federal and state governments (Tables A23–A26). We apportioned the savings from averted Medicaid births according to the 2005 rate of federal reimbursement (the federal medical assistance percentage), which varied by state from 50% to 77% (Tables A23–A26, column 1).⁶⁴ In apportioning the costs of the family planning services provided, we assumed that the costs for family planning services and supplies would be reimbursed at the special 90% federal matching rate for family planning, and that the 10% added to estimate outreach and administrative costs would be reimbursed at the 50% rate that is required for Medicaid administrative costs. Overall, that meant that 86% of the total

program costs were apportioned to the federal government and 14% to the states.

Hypothetical results for states with existing expansions. Finally, in order to illustrate the full impact of expanding eligibility for Medicaid family planning services, we used the methodology developed here to make hypothetical estimates of the number of participants, expected unintended pregnancies averted and cost savings for each the 15 states with existing income-based Medicaid family planning expansions. These numbers represent the participation and impact that would be expected in the third full year of use, on the basis of calculations that begin with 2004 data on age- and income-eligible women who are in need of contraceptive services and supplies, and that apply the same assumptions used here about program scope and utilization. Specifically, as in all of our projections, we assume that the Medicaid expansion program in each state covers only family planning services and supplies that can be reimbursed at the 90% rate, and we project utilization using the national average (Table A27). When added to the results from each of our scenarios, these estimates demonstrate the total contribution of Medicaid family planning expansion programs in reducing unintended pregnancy. For example, under Scenario 200, we estimate that new expansion programs would be used by 3.6 million participants, avert 522,000 unintended pregnancies and save the government a net \$1.6 billion in averted Medicaid birth costs. At the same time, the existing expansion programs in 15 states would be expected to serve 2.2 million participants, avert 323,000 unintended pregnancies and save over \$1 billion. Thus, the overall impact of new and existing Medicaid expansion programs in a one-year period would be the prevention of nearly 850,000 unintended pregnancies, of which 340,000 would have ended in abortion and 403,000 in unintended birth.

In order to present complete and consistent data for the impact of existing expansions, calculation of these hypothetical outcomes was necessary. Actual program data were unavailable for most of the 15 states, and, in fact, five of the programs were in only the first or second year of operation. Among states that did have program data, the scope of the program, the timing of the evaluation or the eligibility criteria typically differed from that measured here. It is not surprising, therefore, that in some of the few cases where complete data for a state's existing program were available, our estimates of unintended births averted diverged substantially. It should be noted that most state evaluations are con-

ducted to demonstrate budget neutrality and therefore primarily focus on births averted, specifically those births that would be covered by Medicaid. With the exception of California, states have not tried to measure program impact on all unintended pregnancies, including the reduction of abortions, because abortions are generally not paid for with public dollars.

The methodology typically used in state evaluations—as well as in the evaluation of six states funded by CMS and conducted by the CNA Corporation⁶⁵—first estimates the number of births that would have been expected among demonstration participants without the program by applying the age- and race/ethnicity-specific birthrates of a similar population to the age/race/ethnicity distribution of participants. The number of births that actually occurred to participants is then measured by linking family planning and maternity records and counting births occurring to participants who conceived during the program year. Births averted are calculated as the difference between expected and actual births.

These estimates inevitably differ from ours because of the methodological differences used to calculate averted events. Our methodology projects forward in time, estimating outcomes by comparing current contraceptive behavior with an estimate of future contraceptive behavior. In contrast, state evaluations typically project backward, comparing estimates of births that would have occurred in the absence of an expansion with births that actually occurred. Note also that states' evaluations differ in their methodology, for example in their choice of an appropriate population for baseline birthrates.

With these differences in mind, it is still useful to compare our results to some of those made by states or by the CNA Corporation in its six-state evaluation. Beginning with Arkansas, the CNA evaluation estimated that in 1998–1999, 3,200 unintended births were averted among 39,000 participants. A more recent Arkansas state evaluation estimated that in 2002, 2,700 unintended births were averted among 45,000 participants. Following our methodology, we predict 4,300 unintended births averted among 62,000 participants. Although these estimates differ from each other, in all cases the ratio of births averted to participants is between 6% and 8%. In addition, the higher participation rates that we predict are at least partially due to the fact that the earlier evaluation was based on a program with lower eligibility levels—the Arkansas program originally set eligibility at 133% of poverty and it only was raised to 200% FPL at the end of 2001. Thus, the CNA

evaluation relied on data for the 133% expansion program, and the 2002 evaluation data represent results for the first year of the full expansion (whereas our estimates are for the third year).

In Oregon, the CNA evaluation reported that in 2000, about 5,400 unintended births were averted among 53,000 participants. A subsequent Oregon evaluation reported that in 2001, the third year of the expansion, 9,300 unintended births were prevented among 82,000 participants. We predict 5,400 births averted among 77,000 participants in Oregon. In South Carolina, the state evaluation estimated 3,000 unintended births averted among 64,000 participants in 2000, that program's third full year. We predict 5,100 unintended births averted among 74,000 participants. (The CNA evaluation looked only at an earlier South Carolina expansion, limited to women leaving Medicaid postpartum.) The ratio of births averted to participants shows considerable variability among these evaluations (and from year to year for each state), from 5% in the South Carolina evaluation to 11% in Oregon's; our ratio—for these and every state—was 7%. Note that the state evaluations present data through the fifth or sixth year of the expansions; participation in Oregon continued to grow past the third year, while it remained flat in South Carolina.

The biggest Medicaid eligibility expansion program in the country, and the one that has been most rigorously evaluated, is the California program, Family PACT. The CNA evaluation used California program data from a 12-month period during 1999–2000, the first year after the program was granted federal approval as a Medicaid eligibility expansion program (prior to that date that program operated as a state-only program). In that year, CNA estimated that 11,500 unintended births were averted among 418,000 participants. (However, this evaluation purposefully included only those participants who were able to provide valid social security numbers and therefore is based on far fewer participants than actually received services.) The ratio of births averted to program participants estimated by CNA for California is quite low (3%), and it is unclear what might explain this finding.

A thorough evaluation of the program was completed for 2002 by researchers at the University of California, San Francisco (UCSF).⁶⁶ In that year, 926,000 women received contraceptive services. The UCSF evaluation was somewhat similar to ours in its methodology for estimating the overall numbers of unintended pregnancies that would be expected and averted among contraceptive users, on the basis of the distri-

bution of contraceptive methods used by women prior to the program and after joining the program. (Their “before” population was based on reviewing the charts of a small subgroup of enrollees who provided information on the method of contraception used prior to joining the program. The contraceptive method mix for their “after” population was drawn from actual claims data that showed the number of months each method was dispensed and paid for by the program; methods paid for by other sources, including private funds, were not included in these “after” data.)

Using this methodology, the researchers estimated that 94,000 unintended births were averted in 2002 among female clients, a number that produces a ratio of births averted to contraceptive users of about 10%. However, these numbers only represent part of the story for California's program. In addition to the 926,000 women who received contraceptive services, the program dispensed contraceptives to another 113,000 male clients, averting an estimated 3,800 unintended births. The entire program, which includes provision of a variety of noncontraceptive services, is reported to have served nearly 1.5 million clients in 2002. So, if one calculates the ratio of unintended births averted to total program users, the ratio drops to about 6.5%.

Interestingly, when looking just at contraceptive users, we produce estimates quite similar to those reported by UCSF. We estimate that among 902,000 women served in the third year of an expansion program in California, 62,100 unintended births would be averted. The basic difference between these results can be attributed to differences in the number of unintended births expected among participants prior to program use. Because we based our “before” population on women who were potential participants, even if they had received recent publicly funded contraceptive services (so as to compensate for the substitution effect), the method mix on which we based our assessment of expected pregnancies had higher percentages of women using any method and using more effective methods than those in the method mix that the UCSF group used to approximate preprogram behavior. These differences in expected preprogram method use result in more or fewer unintended pregnancies predicted among women prior to joining the program and consequently more or fewer unintended pregnancies and births averted.

Estimates of cost savings made by the UCSF evaluation also differ considerably from our results. One major reason is that UCSF included costs for a range of

noncontraceptive services that are covered by the current California program. Our estimates, in contrast, include only the family planning services and supplies covered at the 90% matching rate (plus 10% for outreach and administrative costs) and therefore result in much lower program costs per person. These differences are to be expected, given the more limited scope of the expansion program modeled here and likely to be implemented on a nationwide scale. States that choose to implement programs as broad as California's Family PACT program will need to plan for much higher costs than those estimated here.

TABLE A1. Calculations to separate 19-year-olds from adolescent subgroup

State	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	2002 adolescents in need of family planning				2004 adolescents in need of family planning		
	Total aged 13–19	Aged 13–17	Aged 18–19	Estimated % aged 19	Total aged 13–19	Estimated aged 13–18	Estimated aged 19
U.S. total	4,867,240	2,227,640	2,639,610	27.12	5,004,800	3,648,400	1,356,400
Alabama	82,280	37,500	44,780	27.21	82,900	60,300	22,500
Alaska	10,090	4,630	5,460	27.06	10,400	7,600	2,800
Arizona	83,850	37,360	46,490	27.72	89,500	64,700	24,800
Arkansas	48,940	22,140	26,800	27.38	49,100	35,700	13,500
California	568,650	270,940	297,710	26.18	599,700	442,700	157,000
Colorado	64,880	28,020	36,860	28.41	66,700	47,800	19,000
Connecticut	59,440	28,910	30,530	25.68	62,600	46,500	16,100
Delaware	13,350	5,550	7,800	29.21	13,800	9,700	4,000
District of Columbia	8,270	2,760	5,510	33.31	8,500	5,600	2,800
Florida	253,820	120,380	133,440	26.29	270,000	199,000	71,000
Georgia	152,330	71,020	81,310	26.69	159,400	116,800	42,500
Hawaii	15,840	6,630	9,210	29.07	16,100	11,400	4,700
Idaho	21,300	8,750	12,550	29.46	21,400	15,100	6,300
Illinois	221,650	105,220	116,430	26.26	226,300	166,900	59,400
Indiana	105,480	45,290	60,190	28.53	107,600	76,900	30,700
Iowa	49,530	20,460	29,070	29.35	48,800	34,500	14,300
Kansas	48,560	21,720	26,840	27.64	47,800	34,600	13,200
Kentucky	67,130	28,610	38,520	28.69	67,400	48,100	19,300
Louisiana	93,610	44,100	49,510	26.44	91,800	67,500	24,300
Maine	23,080	10,830	12,250	26.54	23,200	17,000	6,200
Maryland	91,070	43,790	47,280	25.96	95,800	70,900	24,900
Massachusetts	106,710	47,240	59,470	27.87	109,600	79,000	30,500
Michigan	175,910	80,140	95,770	27.22	181,300	132,000	49,400
Minnesota	86,390	38,090	48,300	27.95	86,300	62,200	24,100
Mississippi	60,030	27,930	32,100	26.74	59,600	43,600	15,900
Missouri	99,780	44,430	55,350	27.74	100,500	72,600	27,900
Montana	13,090	5,350	7,740	29.56	12,800	9,000	3,800
Nebraska	30,710	13,570	17,140	27.91	30,200	21,800	8,400
Nevada	30,210	13,740	16,470	27.26	33,500	24,400	9,100
New Hampshire	23,010	10,350	12,660	27.51	24,000	17,400	6,600
New Jersey	144,100	73,490	70,610	24.50	151,300	114,300	37,100
New Mexico	33,460	16,330	17,130	25.60	33,600	25,000	8,600
New York	340,120	163,040	177,080	26.03	349,300	258,400	90,900
North Carolina	136,970	60,460	76,510	27.93	145,200	104,600	40,500
North Dakota	11,140	4,620	6,520	29.26	10,600	7,500	3,100
Ohio	195,930	87,480	108,450	27.68	197,800	143,100	54,700
Oklahoma	62,270	27,350	34,920	28.04	61,100	43,900	17,100
Oregon	48,190	19,570	28,620	29.69	48,700	34,300	14,500
Pennsylvania	220,070	99,390	120,680	27.42	225,500	163,700	61,800
Rhode Island	18,580	7,470	11,110	29.90	19,400	13,600	5,800
South Carolina	74,450	33,240	41,210	27.68	76,700	55,500	21,200
South Dakota	13,760	6,010	7,750	28.16	13,300	9,600	3,700
Tennessee	97,010	42,720	54,290	27.98	99,400	71,600	27,800
Texas	373,850	174,540	199,310	26.66	383,200	281,000	102,100
Utah	40,110	14,500	25,610	31.92	39,000	26,600	12,500
Vermont	11,530	5,140	6,390	27.71	11,500	8,300	3,200
Virginia	119,930	54,350	65,580	27.34	125,100	90,900	34,200
Washington	85,310	35,240	50,070	29.35	86,700	61,300	25,400
West Virginia	28,360	11,920	16,440	28.88	28,100	19,900	8,100
Wisconsin	95,320	42,100	53,220	27.92	95,500	68,800	26,600
Wyoming	7,790	3,220	4,570	29.33	7,400	5,200	2,200
Column sources and formulas	B2-col. 3 & 4	B2-col. 3	B2-col. 4	$\frac{1}{2}(\text{col. 3}) \div \text{col. 1}$	B1-col. 3	col. 5 – col. 7	col. 4 * col. 5

Notes for all tables: Column sources and formulas refer to other columns in the existing table (e.g., "col. 3" is short for column 3); to columns in other tables (e.g., "A2-col. 1" is short for Table A2, column 1); and to outside sources (e.g., "ref. 18" directs the reader to reference 18 from the References; "FN†" directs the reader to a footnote at the bottom of the table). FPL = federal poverty level. Data presented are often rounded: Numbers of women, for example, are typically rounded to the nearest hundred, and percentages are typically rounded to two decimal places. All calculations were performed using unrounded data. Data presented may not sum to the totals because of rounding. For tables presenting state-level data, all calculations were performed at the state level, except when specifically noted, and national sums and averages are presented for illustration purposes.

TABLE A2. Calculations to estimate poverty-level subgroups of adult women

State	(1)	(2)			(3)	(4)	(5)	(6)			(7)	(8)	(9)	(10)
	2002 women aged 20-44 with incomes <250% FPL	Total	<100% FPL	100-185% FPL	185-250% FPL	Among those with incomes 100-250% FPL, % with incomes 100-200%	2004 women aged 20-44 with incomes <250% FPL	Total	<100% FPL	Estimated 100-200% FPL	Estimated aged 19 with incomes <200% FPL	Total aged 19-44 with incomes <200% FPL		
U.S. total	11,909,500	4,262,600	4,154,500	3,492,500	65.03		12,391,900	4,670,400	5,022,600		583,700	10,276,600		
Alabama	192,700	72,300	64,800	55,600	64.64		199,400	88,100	72,000		11,200	171,200		
Alaska	20,300	5,800	8,000	6,500	65.75		20,600	6,600	9,200		1,000	16,800		
Arizona	253,200	89,800	93,300	70,100	67.14		270,800	104,800	111,500		12,300	228,600		
Arkansas	117,700	40,800	42,700	34,200	65.92		117,100	39,500	51,100		7,800	98,500		
California	1,637,700	616,100	596,900	424,700	68.17		1,716,800	663,000	718,400		71,500	1,452,900		
Colorado	171,900	55,700	61,700	54,400	64.12		177,700	59,200	76,000		8,400	143,600		
Connecticut	106,500	36,100	37,000	33,400	63.68		112,100	42,500	44,400		5,700	92,500		
Delaware	28,000	9,000	9,300	9,600	61.13		31,200	10,100	12,900		1,400	24,400		
District of Columbia	27,600	13,000	7,500	7,200	62.50		29,000	14,800	8,800		1,300	25,000		
Florida	632,400	207,600	221,600	203,300	63.37		625,200	219,400	257,100		30,800	507,300		
Georgia	338,600	115,300	114,000	109,300	62.51		363,600	123,800	149,900		20,600	294,300		
Hawaii	46,200	15,500	16,800	13,900	65.38		43,800	14,600	19,100		1,600	35,300		
Idaho	61,800	19,500	24,200	18,100	67.22		65,600	19,300	31,100		3,300	53,700		
Illinois	483,400	174,100	165,500	143,900	64.39		495,600	197,200	192,200		23,900	413,300		
Indiana	255,200	86,500	89,100	79,600	63.89		267,300	102,400	105,400		11,500	219,300		
Iowa	120,500	39,500	43,100	37,900	64.15		125,900	49,300	49,100		6,900	105,400		
Kansas	111,700	38,000	40,500	33,100	65.57		118,500	40,900	50,800		5,800	97,500		
Kentucky	174,200	65,500	58,800	49,900	64.87		186,500	80,500	68,800		9,900	159,200		
Louisiana	210,700	88,000	67,900	54,800	65.80		206,400	90,800	76,100		13,600	180,500		
Maine	56,200	18,200	20,800	17,100	65.49		58,800	23,400	23,200		2,700	49,300		
Maryland	154,500	48,300	50,100	56,100	59.53		171,900	61,700	65,600		8,400	135,700		
Massachusetts	225,400	87,300	74,400	63,700	64.70		218,700	91,000	82,600		9,100	182,800		
Michigan	406,200	146,900	140,300	119,100	64.85		429,500	177,500	163,400		21,900	362,900		
Minnesota	175,500	55,500	63,700	56,300	64.09		185,600	56,700	82,600		8,500	147,800		
Mississippi	133,900	52,200	45,300	36,300	65.94		131,000	48,000	54,700		7,400	110,200		
Missouri	249,300	86,900	87,800	74,600	64.82		264,900	99,100	107,500		11,800	218,400		
Montana	42,200	15,600	15,900	10,700	69.28		42,200	16,000	18,200		2,400	36,500		
Nebraska	74,400	24,000	27,200	23,300	64.65		81,400	25,200	36,400		3,600	65,200		
Nevada	92,000	28,900	33,800	29,300	64.43		110,200	43,600	43,000		4,200	90,700		
New Hampshire	42,400	13,000	14,500	14,900	61.17		39,500	11,500	17,100		1,900	30,500		
New Jersey	250,400	86,900	84,500	79,000	63.01		246,700	88,300	99,800		10,100	198,200		
New Mexico	92,300	35,800	34,200	22,400	69.68		99,000	41,300	40,200		5,000	86,500		
New York	877,800	368,300	285,000	224,600	66.26		883,300	348,900	354,100		32,600	735,600		
North Carolina	330,700	108,400	113,400	108,800	62.50		360,500	130,700	143,600		21,000	295,400		
North Dakota	29,800	10,400	11,300	8,100	67.96		30,800	10,300	14,000		1,400	25,600		
Ohio	470,700	169,600	160,800	140,300	64.32		480,200	175,500	196,000		21,500	393,000		
Oklahoma	153,400	53,500	56,200	43,700	66.49		151,500	47,600	69,100		7,000	123,700		
Oregon	156,600	55,400	56,100	45,100	65.89		168,700	65,600	67,900		7,000	140,500		
Pennsylvania	497,200	180,700	168,000	148,500	64.07		514,900	208,900	196,100		24,400	429,400		
Rhode Island	49,300	20,300	16,100	12,900	65.97		53,600	23,700	19,700		1,600	45,000		
South Carolina	174,900	58,100	60,400	56,400	63.01		203,100	64,700	87,200		9,600	161,500		
South Dakota	34,300	12,100	12,500	9,700	66.67		38,500	16,100	15,000		2,000	33,000		
Tennessee	236,200	79,800	81,000	75,400	63.11		238,900	97,800	89,000		12,200	199,100		
Texas	973,600	341,000	349,000	283,700	65.67		1,033,400	376,100	431,700		52,900	860,700		
Utah	113,700	34,600	41,100	38,100	63.14		120,300	34,400	54,200		4,400	93,000		
Vermont	25,900	8,600	9,300	8,000	64.63		23,800	7,500	10,500		1,200	19,200		
Virginia	251,700	80,100	86,100	85,500	61.86		261,900	89,000	106,900		11,500	207,400		
Washington	244,800	86,800	86,900	71,100	65.55		252,300	98,800	100,600		11,400	210,900		
West Virginia	77,900	33,100	25,600	19,300	67.07		76,200	33,300	28,800		3,700	65,800		
Wisconsin	205,200	67,200	72,700	65,200	63.80		225,300	82,800	90,900		11,600	185,300		
Wyoming	21,000	7,100	8,000	5,800	67.76		22,200	8,400	9,300		1,100	18,800		
Column sources and formulas	col. 2 + col. 3 + col. 4	B2-col. 7	B2-col. 8 & 9	B2-col. 10	(col. 3 + (23%*col. 4)) ÷ (col. 3 + col. 4)		B1-col. 5 & 6	B1-col. 5	col. 5 * B1-col. 6		A1-col. 7 * B3-col. 1 & 2	col. 7 + col. 8 + col. 9		

TABLE A3. Calculations to estimate adult income eligibility under Scenario 250

State	(1)	(2)	(3)			(6)	(7)	(8)
	Aged 19–44 with incomes <100% FPL	Aged 20–44 with incomes 100–250% FPL	Total aged 19 in need	% with incomes 100–200% FPL	Estimated % with incomes 100–250% FPL	Aged 19, in need, with incomes 100–250% FPL	Total aged 19–44 with incomes 100–250% FPL	Total aged 19–44 with incomes <250% FPL
U.S. total	4,952,600	7,721,500	1,356,400	22.43	33.64	452,200	8,173,700	13,126,300
Alabama	94,200	111,400	22,500	22.52	33.78	7,600	119,000	213,100
Alaska	7,000	14,000	2,800	21.88	32.82	900	14,900	21,900
Arizona	110,200	166,000	24,800	27.86	41.78	10,400	176,400	286,600
Arkansas	43,700	77,600	13,500	26.96	40.44	5,400	83,000	126,700
California	694,200	1,053,800	157,000	25.66	38.49	60,400	1,114,200	1,808,500
Colorado	62,300	118,500	19,000	28.14	42.21	8,000	126,500	188,800
Connecticut	45,100	69,700	16,100	19.07	28.61	4,600	74,300	119,300
Delaware	10,600	21,100	4,000	21.82	32.73	1,300	22,400	33,000
District of Columbia	15,500	14,100	2,800	20.92	31.38	900	15,000	30,600
Florida	234,400	405,800	71,000	22.24	33.37	23,700	429,500	663,800
Georgia	133,700	239,800	42,500	25.19	37.78	16,100	255,800	389,500
Hawaii	15,200	29,200	4,700	19.59	29.39	1,400	30,600	45,800
Idaho	20,500	46,300	6,300	33.42	50.14	3,200	49,400	69,900
Illinois	210,100	298,400	59,400	18.54	27.81	16,500	314,900	525,100
Indiana	107,000	164,900	30,700	22.45	33.68	10,300	175,200	282,300
Iowa	52,700	76,600	14,300	24.55	36.83	5,300	81,900	134,600
Kansas	43,500	77,500	13,200	23.95	35.92	4,700	82,300	125,800
Kentucky	86,100	106,000	19,300	22.18	33.27	6,400	112,400	198,500
Louisiana	98,900	115,600	24,300	22.86	34.29	8,300	123,900	222,800
Maine	24,900	35,500	6,200	19.02	28.53	1,800	37,200	62,100
Maryland	64,700	110,200	24,900	21.84	32.76	8,100	118,300	183,000
Massachusetts	95,900	127,600	30,500	13.95	20.93	6,400	134,000	229,900
Michigan	188,600	251,900	49,400	22.14	33.21	16,400	268,300	456,900
Minnesota	59,600	128,900	24,100	23.45	35.17	8,500	137,400	196,900
Mississippi	52,600	83,000	15,900	17.77	26.66	4,200	87,200	139,800
Missouri	104,400	165,800	27,900	23.41	35.12	9,800	175,600	280,000
Montana	17,400	26,200	3,800	25.80	38.70	1,500	27,700	45,100
Nebraska	27,200	56,300	8,400	19.09	28.64	2,400	58,700	85,900
Nevada	45,300	66,700	9,100	26.60	39.90	3,600	70,300	115,700
New Hampshire	12,300	28,000	6,600	15.42	23.13	1,500	29,500	41,900
New Jersey	92,700	158,400	37,100	15.42	23.14	8,600	167,000	259,700
New Mexico	44,000	57,700	8,600	26.99	40.49	3,500	61,200	105,200
New York	367,000	534,400	90,900	15.96	23.94	21,800	556,200	923,100
North Carolina	141,000	229,800	40,500	26.48	39.72	16,100	245,900	386,900
North Dakota	11,000	20,500	3,100	23.42	35.13	1,100	21,600	32,600
Ohio	188,100	304,700	54,700	16.28	24.42	13,400	318,100	506,100
Oklahoma	50,600	103,900	17,100	23.86	35.78	6,100	110,000	160,600
Oregon	68,900	103,100	14,500	25.90	38.86	5,600	108,700	177,600
Pennsylvania	221,400	306,100	61,800	19.29	28.94	17,900	324,000	545,400
Rhode Island	24,600	29,900	5,800	12.33	18.49	1,100	31,000	55,500
South Carolina	69,000	138,400	21,200	24.79	37.19	7,900	146,300	215,300
South Dakota	17,100	22,500	3,700	24.00	36.01	1,400	23,800	41,000
Tennessee	104,300	141,100	27,800	20.76	31.15	8,700	149,800	254,100
Texas	401,200	657,300	102,100	27.26	40.89	41,800	699,100	1,100,200
Utah	36,000	85,900	12,500	22.18	33.27	4,100	90,000	126,000
Vermont	8,000	16,300	3,200	21.86	32.79	1,000	17,300	25,300
Virginia	94,300	172,900	34,200	18.19	27.29	9,300	182,200	276,500
Washington	104,100	153,500	25,400	23.95	35.92	9,100	162,700	266,800
West Virginia	35,200	42,900	8,100	22.16	33.24	2,700	45,600	80,800
Wisconsin	87,500	142,400	26,600	26.09	39.14	10,400	152,900	240,400
Wyoming	8,900	13,800	2,200	27.95	41.93	900	14,700	23,600
Column sources and formulas	B1-col. 5 + (A1-col. 7 * B3-col. 1)	B1-col. 6	A1-col. 7	B3-col. 2	col. 4 * 1.5	col. 3 * col. 5	col. 2 + col. 6	col. 1 + col. 7

TABLE A4. Calculations to estimate adult income eligibility under Scenario Pregnancy Care

State	(1) Aged 19–44		(2)	(3) State pregnancy care eligibility level (% FPL)	(4) % with incomes between 100% FPL and eligibility ceiling	(5) Aged 19–44	
	Total with incomes <100% FPL	Total with incomes 100–200% FPL				No. with incomes between 100% FPL and ceiling	No. with incomes < pregnancy care ceiling
U.S. total	4,952,600	5,324,000		–	–	4,601,400	9,554,000
Alabama	94,200	77,100		133%	33.00	25,400	119,600
Alaska	7,000	9,800		175%	75.00	7,400	14,300
Arizona	110,200	118,400		133%	33.00	39,100	149,300
Arkansas	43,700	54,800		200%	100.00	54,800	98,500
California	694,200	758,700		200%	100.00	758,700	1,452,900
Colorado	62,300	81,300		200%	100.00	81,300	143,600
Connecticut	45,100	47,400		185%	85.00	40,300	85,400
Delaware	10,600	13,800		200%	100.00	13,800	24,400
District of Columbia	15,500	9,400		200%	100.00	9,400	25,000
Florida	234,400	272,900		185%	85.00	232,000	466,300
Georgia	133,700	160,600		200%	100.00	160,600	294,300
Hawaii	15,200	20,000		185%	85.00	17,000	32,300
Idaho	20,500	33,200		133%	33.00	11,000	31,500
Illinois	210,100	203,200		200%	100.00	203,200	413,300
Indiana	107,000	112,300		150%	50.00	56,100	163,200
Iowa	52,700	52,700		200%	100.00	52,700	105,400
Kansas	43,500	54,000		150%	50.00	27,000	70,500
Kentucky	86,100	73,000		185%	85.00	62,100	148,200
Louisiana	98,900	81,600		200%	100.00	81,600	180,500
Maine	24,900	24,400		200%	100.00	24,400	49,300
Maryland	64,700	71,000		250%	150.00	118,300	183,000 *
Massachusetts	95,900	86,800		200%	100.00	86,800	182,800
Michigan	188,600	174,300		185%	85.00	148,200	336,700
Minnesota	59,600	88,300		275%	175.00	161,900	221,500 *
Mississippi	52,600	57,500		185%	85.00	48,900	101,500
Missouri	104,400	114,000		185%	85.00	96,900	201,300
Montana	17,400	19,100		133%	33.00	6,300	23,700
Nebraska	27,200	38,000		185%	85.00	32,300	59,500
Nevada	45,300	45,400		133%	33.00	15,000	60,300
New Hampshire	12,300	18,200		185%	85.00	15,400	27,800
New Jersey	92,700	105,500		200%	100.00	105,500	198,200
New Mexico	44,000	42,500		185%	85.00	36,200	80,100
New York	367,000	368,600		200%	100.00	368,600	735,600
North Carolina	141,000	154,400		185%	85.00	131,200	272,200
North Dakota	11,000	14,700		133%	33.00	4,800	15,800
Ohio	188,100	204,900		150%	50.00	102,500	290,500
Oklahoma	50,600	73,100		185%	85.00	62,200	112,700
Oregon	68,900	71,700		185%	85.00	60,900	129,800
Pennsylvania	221,400	208,000		185%	85.00	176,800	398,200
Rhode Island	24,600	20,400		250%	150.00	31,000	55,500 *
South Carolina	69,000	92,500		185%	85.00	78,600	147,600
South Dakota	17,100	15,900		133%	33.00	5,200	22,400
Tennessee	104,300	94,800		185%	85.00	80,600	184,900
Texas	401,200	459,500		185%	85.00	390,600	791,700
Utah	36,000	57,000		133%	33.00	18,800	54,800
Vermont	8,000	11,200		200%	100.00	11,200	19,200
Virginia	94,300	113,200		150%	50.00	56,600	150,900
Washington	104,100	106,700		185%	85.00	90,700	194,800
West Virginia	35,200	30,600		150%	50.00	15,300	50,500
Wisconsin	87,500	97,800		185%	85.00	83,200	170,600
Wyoming	8,900	9,900		133%	33.00	3,300	12,200
Column sources and formulas	B1-col. 5 + (A1-col. 7 * B3-col. 1)	A2-col. 10 – col. 1		ref. 18	col. 3 – 100	col. 2 * col. 4	col. 1 + col. 5

*For three states, the eligibility ceiling for pregnancy care was at or above 250% FPL. For the two states at 250%, Maryland and Rhode Island, the number eligible is the number of women with incomes less than 250% FPL from Table A3. For Minnesota's eligibility level of 275% FPL, we calculated eligible women as the number with incomes <250% FPL (Table A3), plus 50% of the number estimated to have incomes of 200–250% FPL.

TABLE A5. Calculations to estimate percent of adolescent and adult women who are uninsured at all during the year

State	(1)		(2)	(3)	(4)	(5)		(6)	(7)
	% uninsured, aged 13–18			Aged 13–18 uninsured at all during year	% uninsured, aged 19–44		Aged 19–44 with incomes <200% FPL uninsured at all during year		
original % uninsured	adjusted for in- need status (1.22)	adjusted for any period during year (1.83)	original % uninsured		adjusted for any period during year (1.54)				
U.S. total	13.76	16.77	30.67	1,111,200	38.44	59.36	6,015,600		
Alabama	11.08	13.50	24.70	14,900	35.10	54.19	92,800		
Alaska	13.10	15.97	29.21	2,200	39.69	61.28	10,300		
Arizona	20.08	24.47	44.76	28,900	38.59	59.59	136,200		
Arkansas	14.12	17.20	31.47	11,200	41.50	64.08	63,100		
California	16.28	19.84	36.28	160,600	41.03	63.35	920,500		
Colorado	15.18	18.50	33.84	16,200	44.05	68.02	97,700		
Connecticut	11.47	13.97	25.56	11,900	27.29	42.14	39,000		
Delaware	8.66	10.56	19.31	1,900	27.29	42.14	10,300		
District of Columbia	13.33	16.24	29.71	1,700	25.55	39.45	9,900		
Florida	20.98	25.57	46.78	93,100	44.84	69.23	351,200		
Georgia	13.04	15.89	29.06	33,900	42.80	66.09	194,500		
Hawaii	8.79	10.72	19.60	2,200	22.62	34.92	12,300		
Idaho	13.20	16.08	29.41	4,400	40.04	61.82	33,200		
Illinois	11.99	14.61	26.73	44,600	35.25	54.42	224,900		
Indiana	13.03	15.88	29.04	22,300	35.28	54.48	119,500		
Iowa	6.50	7.93	14.50	5,000	33.13	51.15	53,900		
Kansas	7.33	8.93	16.34	5,700	34.64	53.49	52,200		
Kentucky	10.00	12.18	22.28	10,700	36.62	56.55	90,000		
Louisiana	16.63	20.27	37.07	25,000	47.90	73.96	133,500		
Maine	9.05	11.04	20.18	3,400	21.49	33.18	16,400		
Maryland	11.45	13.95	25.51	18,100	41.70	64.38	87,400		
Massachusetts	9.91	12.08	22.09	17,500	25.95	40.06	73,200		
Michigan	9.47	11.54	21.10	27,900	28.85	44.54	161,600		
Minnesota	8.18	9.97	18.24	11,300	24.96	38.53	57,000		
Mississippi	12.54	15.28	27.95	12,200	39.02	60.25	66,400		
Missouri	6.66	8.12	14.85	10,800	30.84	47.62	104,000		
Montana	17.86	21.77	39.81	3,600	40.57	62.65	22,900		
Nebraska	6.73	8.20	15.00	3,300	32.20	49.72	32,400		
Nevada	17.95	21.88	40.01	9,800	45.09	69.61	63,200		
New Hampshire	7.34	8.95	16.37	2,900	39.49	60.97	18,600		
New Jersey	12.87	15.69	28.69	32,800	41.66	64.32	127,500		
New Mexico	16.40	19.98	36.55	9,100	47.58	73.47	63,600		
New York	9.82	11.96	21.88	56,500	32.81	50.66	372,700		
North Carolina	15.05	18.35	33.55	35,100	39.97	61.71	182,300		
North Dakota	9.35	11.39	20.84	1,600	23.42	36.16	9,300		
Ohio	9.02	10.99	20.10	28,800	31.12	48.06	188,900		
Oklahoma	23.10	28.15	51.48	22,600	42.63	65.81	81,400		
Oregon	15.28	18.62	34.05	11,700	40.69	62.82	88,300		
Pennsylvania	9.20	11.21	20.50	33,600	31.93	49.30	211,700		
Rhode Island	6.62	8.07	14.76	2,000	24.50	37.82	17,000		
South Carolina	9.78	11.92	21.79	12,100	33.47	51.68	83,400		
South Dakota	9.50	11.58	21.18	2,000	26.18	40.42	13,300		
Tennessee	8.12	9.89	18.09	12,900	26.30	40.61	80,900		
Texas	26.84	32.71	59.82	168,100	54.96	84.85	730,300		
Utah	8.79	10.72	19.60	5,200	30.27	46.74	43,500		
Vermont	7.88	9.61	17.57	1,500	20.91	32.29	6,200		
Virginia	12.00	14.63	26.76	24,300	41.46	64.02	132,800		
Washington	11.50	14.02	25.63	15,700	34.84	53.79	113,400		
West Virginia	12.18	14.84	27.15	5,400	42.32	65.34	43,000		
Wisconsin	7.54	9.18	16.80	11,600	23.36	36.07	66,900		
Wyoming	12.00	14.63	26.76	1,400	39.31	60.70	11,400		
Column sources and formulas	B4-col. 1	col. 1 * 1.22	col. 2 * 1.83	A1-col. 6 * col. 3	B5-col. 1	col. 5 * 1.54	A2-col. 10 * col. 6		

TABLE A6. Calculations to estimate potential and expected participants in existing expansions

State	(1) Women in need, 2004		(3) Expansion eligibility level (current)	(4) % with incomes between 100% FPL and eligibility ceiling	(5) Women in need with incomes between 100% FPL and ceiling	(6) Uninsured at all during year		(8) Total potential participants in current expansion	(9) Expected participants in third full year (83.45% of potential)
	Aged 19–44 with incomes <100% FPL	Aged 19–44 with incomes 100–200% FPL				Women in need aged 13–18	Women in need aged 19–44 with incomes < expansion		
U.S. total	2,117,500	2,270,600	–	–	2,104,400	417,600	2,377,000	2,794,500	2,332,000
Alabama	94,200	77,100	133%	33.00	25,400	14,900	64,800	79,700	66,500
Arkansas	43,700	54,800	200%	100.00	54,800	11,200	63,100	74,300	62,000
California	694,200	758,700	200%	100.00	758,700	160,600	920,500	1,081,100	902,200
Iowa	52,700	52,700	200%	100.00	52,700	5,000	53,900	58,900	49,200
Michigan	188,600	174,300	185%	85.00	148,200	27,900	150,000	177,800	148,400
Minnesota	59,600	88,300	200%	100.00	88,300	11,300	57,000	68,300	57,000
Mississippi	52,600	57,500	185%	85.00	48,900	12,200	61,200	73,400	61,200
New Mexico	44,000	42,500	185%	85.00	36,200	9,100	58,900	68,000	56,700
New York	367,000	368,600	200%	100.00	368,600	56,500	372,700	429,200	358,200
North Carolina	141,000	154,400	185%	85.00	131,200	35,100	168,000	203,100	169,500
Oklahoma	50,600	73,100	185%	85.00	62,200	22,600	74,200	96,800	80,800
Oregon	68,900	71,700	185%	85.00	60,900	11,700	81,500	93,200	77,800
South Carolina	69,000	92,500	185%	85.00	78,600	12,100	76,300	88,400	73,700
Washington	104,100	106,700	200%	100.00	106,700	15,700	113,400	129,100	107,800
Wisconsin	87,500	97,800	185%	85.00	83,200	11,600	61,600	73,100	61,000
Column sources and formulas	B1-col. 5 + (A1-col. 7 * B3-col. 1)	A1-col. 10 – col. 1	FN*	col. 3 – 100	col. 2 * col. 4	A5-col. 4	A5-col. 6 * (col. 1 + col. 5)	col. 6 + col. 7	col. 8 * 83.45%

* reference 13. *Note:* Although several of these existing expansions are limited to individuals aged 19 and older, the numbers presented here, for methodological reasons, include adolescent women as well.

TABLE A7. Calculations to estimate rate of use among potential participants

State	(1)	(2)	(3)	(4)		(5)	(6)	(7)
	Expansion eligibility level (at time of data)	Potential participants in expansion (at time of data)	Date expansion implemented	Number of users First full year of data	Third full year of data	Rate of use (%) First full year of data	Third full year of data	
Average*	–	–	–	–	–	60.22	83.45	
Alabama†	133%	64,800	10/1/2000	47,495	–	73.28	–	
Arkansas‡	133%	50,800	9/1/1997	31,001	41,437	61.01	81.54	
California	200%	1,081,100	12/1/1999	642,000	890,567	59.38	82.37	
New Mexico†	185%	58,900	7/1/1998	3,219	11,147	5.47	18.94	
Oregon	185%	93,200	1/1/1999	46,201	81,610	49.57	87.55	
South Carolina	185%	88,400	6/1/1997	62,902	63,545	71.18	71.91	
Washington	200%	129,100	7/1/2001	79,189	121,219	61.33	93.87	
Wisconsin	185%	73,100	1/1/2003	33,494	–	45.81	–	
Column sources and formulas	FN‡	A6-col. 8	FN§	ref. 25	ref. 25	col. 4 ÷ col. 2	col. 5 ÷ col. 2	

*New Mexico was excluded from these averages as an outlier. †This expansion is limited to individuals aged 19 and older. ‡At the time of the data, Arkansas had an expansion up to 133% FPL; since then, the state has increased its eligibility limit to 200% FPL.

§Guttmacher Institute, special analysis of data from CMS and state agencies, 2006.

TABLE A8. Calculations to estimate potential and expected participants in a new expansion, third full year

State	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Total potential participants in expansion			New potential participants in states with existing expansion			Expected participants in third full year (83.45% of potential)		
	Scenarios 200 and 200 Optional	Scenario 250	Scenario Pregnancy Care	Scenarios 200 and 200 Optional	Scenario 250	Scenario Pregnancy Care	Scenarios 200 and 200 Optional	Scenario 250	Scenario Pregnancy Care
U.S. total	7,126,800	8,795,100	6,698,000	90,200	740,500	28,400	3,615,300	5,007,500	3,264,600
Optional states	3,114,800	–	–	–	–	–	2,599,300	–	–
New expansions	4,242,100	5,260,100	3,883,700	–	–	–	3,540,000	4,389,500	3,240,900
Alaska	12,500	15,600	11,000	–	–	–	10,400	13,000	9,200
Arizona	165,200	199,700	117,900	–	–	–	137,800	166,700	98,400
Colorado	113,900	144,600	113,900	–	–	–	95,000	120,600	95,000
Connecticut	50,900	62,200	47,900	–	–	–	42,400	51,900	39,900
Delaware	12,100	15,800	12,100	–	–	–	10,100	13,200	10,100
District of Columbia	11,500	13,700	11,500	–	–	–	9,600	11,500	9,600
Florida	444,300	552,700	415,900	–	–	–	370,800	461,200	347,100
Georgia	228,400	291,400	228,400	–	–	–	190,600	243,200	190,600
Hawaii	14,600	18,200	13,500	–	–	–	12,100	15,200	11,300
Idaho	37,600	47,700	23,900	–	–	–	31,400	39,800	19,900
Illinois	269,500	330,400	269,500	–	–	–	224,900	275,700	224,900
Indiana	141,800	176,100	111,200	–	–	–	118,300	147,000	92,800
Kansas	57,800	72,900	43,400	–	–	–	48,300	60,900	36,200
Kentucky	100,700	123,000	94,500	–	–	–	84,000	102,600	78,900
Louisiana	158,500	189,800	158,500	–	–	–	132,300	158,400	132,300
Maine	19,800	24,000	19,800	–	–	–	16,500	20,100	16,500
Maryland	105,500	135,900	135,900	–	–	–	88,000	113,400	113,400
Massachusetts	90,700	109,600	90,700	–	–	–	75,700	91,500	75,700
Missouri	114,800	144,100	106,700	–	–	–	95,800	120,300	89,000
Montana	26,500	31,800	18,500	–	–	–	22,100	26,600	15,400
Nebraska	35,700	46,000	32,800	–	–	–	29,800	38,400	27,400
Nevada	72,900	90,300	51,800	–	–	–	60,900	75,300	43,200
New Hampshire	21,400	28,400	19,800	–	–	–	17,900	23,700	16,500
New Jersey	160,300	199,800	160,300	–	–	–	133,800	166,700	133,800
North Dakota	10,800	13,300	7,300	–	–	–	9,000	11,100	6,100
Ohio	217,600	272,000	168,400	–	–	–	181,600	227,000	140,500
Pennsylvania	245,300	302,500	229,900	–	–	–	204,700	252,400	191,900
Rhode Island	19,000	23,000	23,000	–	–	–	15,900	19,200	19,200
South Dakota	15,400	18,600	11,100	–	–	–	12,800	15,500	9,200
Tennessee	93,800	116,100	88,100	–	–	–	78,300	96,900	73,500
Texas	898,500	1,101,800	840,000	–	–	–	749,800	919,400	701,000
Utah	48,700	64,100	30,800	–	–	–	40,600	53,500	25,700
Vermont	7,700	9,600	7,700	–	–	–	6,400	8,000	6,400
Virginia	157,100	201,300	120,900	–	–	–	131,100	168,000	100,900
West Virginia	48,400	58,200	38,400	–	–	–	40,400	48,600	32,100
Wyoming	12,800	15,700	8,800	–	–	–	10,700	13,100	7,300
Existing expansions	2,884,800	3,535,000	2,814,300	90,200	740,500	28,400	75,300	617,900	23,700
Alabama	107,700	130,400	79,700	28,000	50,700	0	23,300	42,300	0
Arkansas	74,300	92,400	74,300	0	18,100	0	0	15,100	0
California	1,081,100	1,306,400	1,081,100	0	225,300	0	0	188,000	0
Iowa	58,900	73,800	58,900	0	14,900	0	0	12,500	0
Michigan	189,500	231,400	177,800	11,600	53,500	0	9,700	44,700	0
Minnesota	68,300	87,200	96,700	0	18,900	28,400	0	15,800	23,700
Mississippi	78,600	96,500	73,400	5,200	23,100	0	4,300	19,300	0
New Mexico	72,700	86,400	68,000	4,700	18,400	0	3,900	15,400	0
New York	429,200	524,300	429,200	0	95,000	0	0	79,300	0
North Carolina	217,400	273,900	203,100	14,300	70,800	0	11,900	59,100	0
Oklahoma	104,000	128,300	96,800	7,200	31,500	0	6,000	26,300	0
Oregon	100,000	123,200	93,200	6,800	30,000	0	5,600	25,100	0
South Carolina	95,500	123,400	88,400	7,200	35,000	0	6,000	29,200	0
Washington	129,100	159,200	120,500	0	30,100	0	0	25,100	0
Wisconsin	78,400	98,300	73,100	5,300	25,100	0	4,400	21,000	0
Column sources and formulas	2.2-col. 3	2.2-col. 4	2.2-col. 5	col. 1 – A6-col. 8	col. 2 – A6-col. 8	col. 3 – A6-col. 8	(col. 1 or col. 4) * 83.45%	(col. 2 or col. 5) * 83.45%	(col. 3 or col. 6) * 83.45%

TABLE A9. Expected distribution of women according to contraceptive method use prior to and after implementation of a Medicaid family planning expansion, average failure rate for each method, and total unintended pregnancies expected given each method-use pattern, 2002

Method	(1)	(2)		(3)		(4)		(5)	
	One-year failure rate*	Before: Women who would be potential participants in the expansion†		After: Women who currently use publicly funded family planning services					
		No.	%	No.	%	No.	%	No.	%
Total	–	4,490,812	100.0	4,490,811	100.0				
Condom	14.7	964,681	21.48	775,104	17.26				
Injectable	1.4	614,268	13.68	1,055,836	23.51				
Diaphragm/cervical cap	15.9	11,299	0.25	2,465	0.05				
IUD	1.4	242,163	5.39	248,073	5.52				
Implant	2.6	80,117	1.78	21,302	0.47				
Natural family planning/periodic abstinence	25.3	123,884	2.76	24,607	0.55				
Pill	8.1	1,163,983	25.92	1,759,622	39.18				
Spermicide/sponge	29.0	5,078	0.11	41,486	0.92				
Withdrawal/other	27.1	318,755	7.10	255,977	5.70				
No method	85.0	966,584	21.52	0	0.00				
Tubal sterilization this year	0.5	0	0.00	306,339	6.82				
Contraceptive protection index‡			72.6		91.9				
Expected unintended pregnancies			1,014,316		366,246				
Unintended pregnancies averted									648,070
Unintended pregnancies averted per 1,000 participants									144.3

* Subgroup-specific failure rates were used in the analysis, but figures in this column represent failure rates for the whole population (see Table B6); no-method failure rates vary by age, but the figure shown is the average for this population. †Includes women in the National Survey of Family Growth who were at risk for unintended pregnancy, uninsured at some point in the prior year, and either younger than 19 or aged 19–44 and with incomes <200% of poverty. We included all women fitting these criteria, even if they had made a visit to a publicly funded provider (so long as they did not have private health insurance or Medicaid). ‡The contraceptive protection index is calculated by multiplying the proportion of women using each method by that method's protection rate (the inverse of the failure rate) and summing the results. Sources: references 24 and 26.

TABLE A10. Calculations to estimate potential and expected participants in an expansion who would also be eligible for pregnancy-related care under Medicaid

State	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Women in need, 2004			State pregnancy care eligibility level	Equivalent level when pregnant	% with incomes 100–200% FPL and eligible	Women in need with incomes 100–200% FPL and eligible	% with incomes 200–250% FPL and eligible	Women in need with incomes 200–250% FPL and eligible
Aged 19–44 with incomes <100% FPL	Aged 19–44 with incomes 100–200% FPL	Aged 19–44 with incomes 200–250% FPL							
U.S. total	4,952,600	5,324,000	2,849,700	–	–	–	4,991,400	–	988,900
New expansions	2,835,000	3,053,500	1,685,500	–	–	–	2,757,600	–	482,400
Alaska	7,000	9,800	5,100	175%	200.26%	100.00	9,800	0.52	<100
Arizona	110,200	118,400	58,000	133%	152.20%	52.20	61,800	0.00	0
Colorado	62,300	81,300	45,200	200%	228.87%	100.00	81,300	57.74	26,100
Connecticut	45,100	47,400	26,800	185%	211.70%	100.00	47,400	23.41	6,300
Delaware	10,600	13,800	8,600	200%	228.87%	100.00	13,800	57.74	5,000
District of Columbia	15,500	9,400	5,600	200%	228.87%	100.00	9,400	57.74	3,200
Florida	234,400	272,900	156,500	185%	211.70%	100.00	272,900	23.41	36,600
Georgia	133,700	160,600	95,200	200%	228.87%	100.00	160,600	57.74	55,000
Hawaii	15,200	20,000	10,600	185%	211.70%	100.00	20,000	23.41	2,500
Idaho	20,500	33,200	16,200	133%	152.20%	52.20	17,300	0.00	0
Illinois	210,100	203,200	111,800	200%	228.87%	100.00	203,200	57.74	64,500
Indiana	107,000	112,300	63,000	150%	171.65%	71.65	80,400	0.00	0
Kansas	43,500	54,000	28,300	150%	171.65%	71.65	38,700	0.00	0
Kentucky	86,100	73,000	39,400	185%	211.70%	100.00	73,000	23.41	9,200
Louisiana	98,900	81,600	42,300	200%	228.87%	100.00	81,600	57.74	24,400
Maine	24,900	24,400	12,800	200%	228.87%	100.00	24,400	57.74	7,400
Maryland	64,700	71,000	47,300	250%	286.09%	100.00	71,000	100.00	47,300
Massachusetts	95,900	86,800	47,200	200%	228.87%	100.00	86,800	57.74	27,200
Missouri	104,400	114,000	61,600	185%	211.70%	100.00	114,000	23.41	14,400
Montana	17,400	19,100	8,500	133%	152.20%	52.20	10,000	0.00	0
Nebraska	27,200	38,000	20,700	185%	211.70%	100.00	38,000	23.41	4,800
Nevada	45,300	45,400	24,900	133%	152.20%	52.20	23,700	0.00	0
New Hampshire	12,300	18,200	11,400	185%	211.70%	100.00	18,200	23.41	2,700
New Jersey	92,700	105,500	61,500	200%	228.87%	100.00	105,500	57.74	35,500
North Dakota	11,000	14,700	6,900	133%	152.20%	52.20	7,700	0.00	0
Ohio	188,100	204,900	113,200	150%	171.65%	71.65	146,800	0.00	0
Pennsylvania	221,400	208,000	115,900	185%	211.70%	100.00	208,000	23.41	27,100
Rhode Island	24,600	20,400	10,500	250%	286.09%	100.00	20,400	100.00	10,500
South Dakota	17,100	15,900	7,900	133%	152.20%	52.20	8,300	0.00	0
Tennessee	104,300	94,800	54,900	185%	211.70%	100.00	94,800	23.41	12,900
Texas	401,200	459,500	239,600	185%	211.70%	100.00	459,500	23.41	56,100
Utah	36,000	57,000	33,000	133%	152.20%	52.20	29,800	0.00	0
Vermont	8,000	11,200	6,100	200%	228.87%	100.00	11,200	57.74	3,500
Virginia	94,300	113,200	69,100	150%	171.65%	71.65	81,100	0.00	0
West Virginia	35,200	30,600	15,000	150%	171.65%	71.65	21,900	0.00	0
Wyoming	8,900	9,900	4,700	133%	152.20%	52.20	5,200	0.00	0
Existing expansions	2,117,500	2,270,600	1,164,200	–	–	–	2,233,700	–	506,500
Alabama	94,200	77,100	41,900	133%	152.20%	52.20	40,200	0.00	0
Arkansas	43,700	54,800	28,300	200%	228.87%	100.00	54,800	57.74	16,300
California	694,200	758,700	355,600	200%	228.87%	100.00	758,700	57.74	205,300
Iowa	52,700	52,700	29,200	200%	228.87%	100.00	52,700	57.74	16,900
Michigan	188,600	174,300	94,000	185%	211.70%	100.00	174,300	23.41	22,000
Minnesota	59,600	88,300	49,100	275%	314.70%	100.00	88,300	100.00	49,100
Mississippi	52,600	57,500	29,700	185%	211.70%	100.00	57,500	23.41	6,900
New Mexico	44,000	42,500	18,700	185%	211.70%	100.00	42,500	23.41	4,400
New York	367,000	368,600	187,600	200%	228.87%	100.00	368,600	57.74	108,300
North Carolina	141,000	154,400	91,500	185%	211.70%	100.00	154,400	23.41	21,400
Oklahoma	50,600	73,100	36,900	185%	211.70%	100.00	73,100	23.41	8,600
Oregon	68,900	71,700	37,000	185%	211.70%	100.00	71,700	23.41	8,700
South Carolina	69,000	92,500	53,800	185%	211.70%	100.00	92,500	23.41	12,600
Washington	104,100	106,700	55,900	185%	211.70%	100.00	106,700	23.41	13,100
Wisconsin	87,500	97,800	55,000	185%	211.70%	100.00	97,800	23.41	12,900
Column sources and formulas	A4-col. 1	A4-col. 2	A3-col. 8 – (col. 1 + col. 2)	ref. 18	col. 4 * (1.14)	col. 5 – 100 (max. = 100)	col. 2 * col. 6	2 * (col. 5 – 200) (max. = 100)	col. 3 * col. 8

TABLE A11. Calculations to estimate potential and expected participants in an expansion who would also be eligible for pregnancy-related care under Medicaid (continued)

State	(1) (2) (3)			(4) (5)		(6) (7)		(8) (9)	
	Uninsured at all during year			Total potential participants in expansion		New potential participants in states with existing expansion		Expected participants in third full year (83.45% of potential)	
	Women in need aged 13–18	Women in need aged 19–44 with incomes <200% FPL and eligible	Women in need aged 19–44 with incomes <250% FPL and eligible	Scenario 200	Scenario 250	Scenario 200	Scenario 250	Scenario 200	Scenario 250
U.S. total	1,111,200	5,830,400	6,406,800	6,941,600	7,518,000	70,300	353,000	2,532,400	3,941,700
New expansions	693,600	3,383,200	3,676,800	4,076,800	4,370,500	–	–	3,402,100	3,647,100
Alaska	2,200	10,300	10,300	12,500	12,500	–	–	10,400	10,400
Arizona	28,900	102,500	102,500	131,400	131,400	–	–	109,700	109,700
Colorado	16,200	97,700	115,400	113,900	131,600	–	–	95,000	109,800
Connecticut	11,900	39,000	41,600	50,900	53,500	–	–	42,400	44,700
Delaware	1,900	10,300	12,400	12,100	14,200	–	–	10,100	11,900
District of Columbia	1,700	9,900	11,100	11,500	12,800	–	–	9,600	10,700
Florida	93,100	351,200	376,600	444,300	469,700	–	–	370,800	391,900
Georgia	33,900	194,500	230,800	228,400	264,800	–	–	190,600	221,000
Hawaii	2,200	12,300	13,200	14,600	15,400	–	–	12,100	12,900
Idaho	4,400	23,400	23,400	27,800	27,800	–	–	23,200	23,200
Illinois	44,600	224,900	260,100	269,500	304,700	–	–	224,900	254,200
Indiana	22,300	102,100	102,100	124,500	124,500	–	–	103,900	103,900
Kansas	5,700	44,000	44,000	49,600	49,600	–	–	41,400	41,400
Kentucky	10,700	90,000	95,200	100,700	105,900	–	–	84,000	88,400
Louisiana	25,000	133,500	151,500	158,500	176,600	–	–	132,300	147,400
Maine	3,400	16,400	18,800	19,800	22,300	–	–	16,500	18,600
Maryland	18,100	87,400	117,900	105,500	135,900	–	–	88,000	113,400
Massachusetts	17,500	73,200	84,100	90,700	101,600	–	–	75,700	84,800
Missouri	10,800	104,000	110,900	114,800	121,700	–	–	95,800	101,500
Montana	3,600	17,200	17,200	20,800	20,800	–	–	17,300	17,300
Nebraska	3,300	32,400	34,800	35,700	38,100	–	–	29,800	31,800
Nevada	9,800	48,100	48,100	57,800	57,800	–	–	48,200	48,200
New Hampshire	2,900	18,600	20,200	21,400	23,100	–	–	17,900	19,200
New Jersey	32,800	127,500	150,300	160,300	183,100	–	–	133,800	152,800
North Dakota	1,600	6,700	6,700	8,300	8,300	–	–	6,900	6,900
Ohio	28,800	160,900	160,900	189,700	189,700	–	–	158,300	158,300
Pennsylvania	33,600	211,700	225,100	245,300	258,700	–	–	204,700	215,900
Rhode Island	2,000	17,000	21,000	19,000	23,000	–	–	15,900	19,200
South Dakota	2,000	10,300	10,300	12,300	12,300	–	–	10,300	10,300
Tennessee	12,900	80,900	86,100	93,800	99,100	–	–	78,300	82,700
Texas	168,100	730,300	777,900	898,500	946,100	–	–	749,800	789,500
Utah	5,200	30,700	30,700	35,900	35,900	–	–	30,000	30,000
Vermont	1,500	6,200	7,300	7,700	8,800	–	–	6,400	7,300
Virginia	24,300	112,300	112,300	136,600	136,600	–	–	114,000	114,000
West Virginia	5,400	37,300	37,300	42,700	42,700	–	–	35,700	35,700
Wyoming	1,400	8,500	8,500	9,900	9,900	–	–	8,300	8,300
Existing expansions	417,600	2,447,200	2,729,900	2,864,800	3,147,500	70,300	353,000	58,600	294,600
Alabama	14,900	72,800	72,800	87,700	87,700	8,000	8,000	6,700	6,700
Arkansas	11,200	63,100	73,600	74,300	84,800	0	10,500	0	8,700
California	160,600	920,500	1,050,500	1,081,100	1,211,200	0	130,100	0	108,500
Iowa	5,000	53,900	62,500	58,900	67,500	0	8,600	0	7,200
Michigan	27,900	161,600	171,400	189,500	199,300	11,600	21,400	9,700	17,900
Minnesota	11,300	57,000	75,900	68,300	87,200	0	18,900	0	15,800
Mississippi	12,200	66,400	70,600	78,600	82,800	5,200	9,400	4,300	7,800
New Mexico	9,100	63,600	66,800	72,700	75,900	4,700	7,900	3,900	6,600
New York	56,500	372,700	427,600	429,200	484,100	0	54,900	0	45,800
North Carolina	35,100	182,300	195,500	217,400	230,600	14,300	27,500	11,900	23,000
Oklahoma	22,600	81,400	87,100	104,000	109,700	7,200	12,900	6,000	10,800
Oregon	11,700	88,300	93,700	100,000	105,400	6,800	12,200	5,600	10,200
South Carolina	12,100	83,400	90,000	95,500	102,000	7,200	13,700	6,000	11,400
Washington	15,700	113,400	120,500	129,100	136,200	0	7,000	0	5,900
Wisconsin	11,600	66,900	71,500	78,400	83,100	5,300	9,900	4,400	8,300
Column sources and formulas	A5-col. 4	A10-col. 1 & 7 * A5-col. 6	A10-col. 1, 7 & 9 * A5-col. 6	col. 1 + col. 2	col. 1 + col. 3	col. 4 – A6-col. 8	col. 5 – A6-col. 8	(col. 4 or col. 6) * 83.45%	(col. 5 or col. 7) * 83.45%

TABLE A12. Calculations to estimate the cost per Medicaid birth, by state where data are available

State	(1)	(2)	(3)	(4)	(5)	(6)
	Original data from waiver applications and evaluations				Consumer Price Index inflator	Cost per birth (in 2005 \$)
	Cost per delivery	Cost per infant	Total cost per birth	Year of data		
Alabama	\$4,528	\$2,500	\$7,027	2001	1.18	\$8,325
Arkansas	\$4,293	\$5,222	\$9,515	2002	1.13	\$10,768
California	\$4,571	\$2,362	\$6,933	2000	1.24	\$8,592
Florida	\$2,647	\$6,396	\$9,043	2002	1.13	\$10,234
Illinois	\$3,296	\$4,845	\$8,140	2003	1.09	\$8,855
Iowa	\$3,110	\$9,676	\$12,786	2003	1.09	\$13,909
Louisiana	\$6,215	\$6,619	\$12,834	2003	1.09	\$13,961
Michigan	\$4,200	\$7,300	\$11,500	2002	1.13	\$13,014
Minnesota	\$3,386	\$6,894	\$10,280	2001	1.18	\$12,180
Mississippi	\$3,091	\$1,888	\$4,979	2001	1.18	\$5,899
New Mexico	\$4,702	\$3,917	\$8,619	2002	1.13	\$9,754
New York	u	u	\$11,354	2002	1.13	\$12,849
North Carolina	\$2,327	\$5,061	\$7,388	2001	1.18	\$8,753
Oklahoma	\$2,796	\$4,632	\$7,428	2001	1.18	\$8,800
Oregon	\$3,900	\$3,667	\$7,567	2004	1.04	\$7,887
Pennsylvania	\$2,358	\$1,922	\$4,280	2002	1.13	\$4,843
Rhode Island	\$6,843	\$5,601	\$12,444	2005	1.00	\$12,444
South Carolina	\$3,986	\$4,694	\$8,680	2002	1.13	\$9,822
Texas	\$3,372	\$7,271	\$10,643	2004	1.04	\$11,093
Virginia	u	u	\$7,927	2001	1.18	\$9,392
Washington	\$7,629	\$5,589	\$13,218	2005	1.00	\$13,218
Wisconsin	\$6,850	\$2,253	\$9,103	2003	1.09	\$9,903

Note: u=unavailable. Sources: references 28 and 29.

TABLE A13. Calculations to estimate the cost per Medicaid birth, by state (continued)

State	(1) Cost per birth (in 2005 \$)	(2) Medicaid physician fee index			(5) Medicaid capitation rate, indexed	(6) % Medicaid enrollees in capitation, 2001	(7) Composite index			(10) Final cost per birth (in 2005 \$)
		(3) Index	(4) Adjusted cost per birth	(4) Estimated cost per birth			(8) Index	(8) Adjusted cost per birth	(9) Estimated cost per birth	
U.S. total	–	1.00	\$10,063	–	1.00	–	–	\$10,530	–	\$10,948
Alabama	\$8,325	1.21	\$6,880	–	–	0.00	–	–	–	\$8,325
Alaska	–	2.28	–	\$22,944	–	0.00	–	–	–	\$22,944
Arizona	–	1.55	–	\$15,598	0.84	89.00	0.92	–	\$9,696	\$9,696
Arkansas	\$10,768	1.24	\$8,684	–	–	0.00	–	–	–	\$10,768
California	\$8,592	0.91	\$9,442	–	0.88	52.00	0.90	\$9,589	–	\$8,592
Colorado	–	1.06	–	\$10,667	0.86	46.00	0.97	–	\$10,199	\$10,199
Connecticut	–	1.30	–	\$13,082	1.09	72.00	1.15	–	\$12,063	\$12,063
Delaware	–	1.49	–	\$14,994	1.02	82.00	1.11	–	\$11,657	\$11,657
Dist. of Columbia	–	0.78	–	\$7,849	1.19	63.00	1.04	–	\$10,964	\$10,964
Florida	\$10,234	0.95	\$10,772	–	0.87	27.00	0.93	\$11,021	–	\$10,234
Georgia	–	1.13	–	\$11,371	–	0.00	–	–	–	\$11,371
Hawaii	–	1.14	–	\$11,472	0.95	72.00	1.00	–	\$10,535	\$10,535
Idaho	–	1.22	–	\$12,277	–	0.00	–	–	–	\$12,277
Illinois	\$8,855	0.92	\$9,625	–	0.94	9.00	0.92	\$9,608	–	\$8,855
Indiana	–	0.92	–	\$9,258	1.06	18.00	0.94	–	\$9,946	\$9,946
Iowa	\$13,909	1.30	\$10,699	–	1.16	25.00	1.27	\$10,989	–	\$13,909
Kansas	–	1.00	–	\$10,063	0.86	22.00	0.97	–	\$10,215	\$10,215
Kentucky	–	1.01	–	\$10,164	1.23	20.00	1.05	–	\$11,099	\$11,099
Louisiana	\$13,961	1.04	\$13,424	–	–	0.00	–	–	–	\$13,961
Maine	–	0.89	–	\$8,956	–	0.00	–	–	–	\$8,956
Maryland	–	1.21	–	\$12,176	1.15	68.00	1.17	–	\$12,340	\$12,340
Massachusetts	–	1.25	–	\$12,579	1.10	20.00	1.22	–	\$12,837	\$12,837
Michigan	\$13,014	0.96	\$13,556	–	0.68	62.00	0.78	\$16,611	–	\$13,014
Minnesota	\$12,180	1.09	\$11,174	–	1.30	65.00	1.22	\$9,946	–	\$12,180
Mississippi	\$5,899	1.19	\$4,957	–	–	0.00	–	–	–	\$5,899
Missouri	–	0.76	–	\$7,648	0.97	45.00	0.86	–	\$9,011	\$9,011
Montana	–	1.13	–	\$11,371	–	0.00	–	–	–	\$11,371
Nebraska	–	1.22	–	\$12,277	–	18.00	–	–	–	\$12,277
Nevada	–	1.43	–	\$14,390	0.82	38.00	1.20	–	\$12,620	\$12,620
New Hampshire	–	1.03	–	\$10,365	1.13	8.00	1.04	–	\$10,928	\$10,928
New Jersey	–	0.56	–	\$5,635	0.92	60.00	0.77	–	\$8,151	\$8,151
New Mexico	\$9,754	1.31	\$7,446	–	1.20	64.00	1.24	\$7,876	–	\$9,754
New York	\$12,849	0.70	\$18,355	–	0.96	25.00	0.76	\$16,809	–	\$12,849
North Carolina	\$8,753	1.34	\$6,532	–	1.21	5.00	1.33	\$6,564	–	\$8,753
North Dakota	–	1.23	–	\$12,378	1.34	1.00	1.23	–	\$12,963	\$12,963
Ohio	–	0.97	–	\$9,761	1.04	21.00	0.98	–	\$10,369	\$10,369
Oklahoma	\$8,800	0.95	\$9,264	–	0.76	37.00	0.88	\$10,011	–	\$8,800
Oregon	\$7,887	1.18	\$6,684	–	–	58.00	–	–	–	\$7,887
Pennsylvania	\$4,843	0.74	\$6,545	–	0.85	63.00	0.81	\$5,988	–	\$4,843
Rhode Island	\$12,444	0.62	\$20,071	–	1.02	68.00	0.89	\$13,940	–	\$12,444
South Carolina	\$9,822	1.17	\$8,395	–	0.91	4.00	1.16	\$8,471	–	\$9,822
South Dakota	–	1.05	–	\$10,566	–	0.00	–	–	–	\$10,566
Tennessee	–	–	–	–	–	100.00	–	–	–	\$10,948
Texas	\$11,093	0.99	\$11,205	–	0.82	23.00	0.95	\$11,671	–	\$11,093
Utah	–	1.01	–	\$10,164	0.90	60.00	0.94	–	\$9,932	\$9,932
Vermont	–	1.12	–	\$11,271	–	0.00	–	–	–	\$11,271
Virginia	\$9,392	1.08	\$8,696	–	1.22	33.00	1.13	\$8,340	–	\$9,392
Washington	\$13,218	1.24	\$10,660	–	0.99	62.00	1.09	\$12,173	–	\$13,218
West Virginia	–	1.21	–	\$12,176	0.92	16.00	1.16	–	\$12,255	\$12,255
Wisconsin	\$9,903	1.19	\$8,322	–	0.85	40.00	1.05	\$9,399	–	\$9,903
Wyoming	–	1.40	–	\$14,088	–	0.00	–	–	–	\$14,088
Column sources and formulas	A12-col. 6	ref. 30	col. 1 ÷ col. 2	col. 2 * average (col. 3)	ref. 31	ref. 60	FN* col. 1 ÷ col. 7	col. 7 * average (col. 8)	FN†	

*Formula: (col. 5 * col. 6) + (col. 2 * (1 – col. 6)). †In order of preference: column 1 data; column 9 data; column 4 data; or column 10 average.

TABLE A14. Calculations to estimate the cost per user of Medicaid family planning services, among fee-for-service Medicaid users aged 13–44, by state

State	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Original data from MSIS, 2003			Medicaid physician fee index	With estimates for five states		
	Total spent	No. of users	Cost per user		Cost per user, 2003	Cost per user (in 2005 \$)	Cost per user (in 2005 \$) inflated by 10%
U.S. total	\$727,809,075	3,512,630	\$215	1.00	\$215	\$234	\$257
Alabama	\$7,466,770	39,971	\$187	1.21	\$187	\$203	\$224
Alaska	\$898,857	3,028	\$297	2.28	\$297	\$323	\$355
Arizona*	\$242,130	212	\$1,142	1.55	\$333	\$362	\$398
Arkansas	\$17,137,115	78,505	\$218	1.24	\$218	\$237	\$261
California	\$265,085,581	1,559,020	\$170	0.91	\$170	\$185	\$203
Colorado	\$6,114,217	12,709	\$481	1.06	\$481	\$523	\$576
Connecticut	\$810,477	5,029	\$161	1.30	\$161	\$175	\$193
Delaware	\$1,930,505	10,705	\$180	1.49	\$180	\$196	\$216
Dist. of Columbia*	\$1,162,853	1,140	\$1,020	0.78	\$167	\$182	\$200
Florida	\$7,985,897	104,296	\$77	0.95	\$77	\$83	\$92
Georgia	\$2,260,071	19,720	\$115	1.13	\$115	\$125	\$137
Hawaii	\$157,352	831	\$189	1.14	\$189	\$206	\$227
Idaho	\$1,222,022	8,873	\$138	1.22	\$138	\$150	\$165
Illinois	\$44,619,845	139,535	\$320	0.92	\$320	\$348	\$383
Indiana	\$7,211,575	40,828	\$177	0.92	\$177	\$192	\$211
Iowa	\$3,678,235	22,123	\$166	1.30	\$166	\$181	\$199
Kansas	\$3,479,247	16,955	\$205	1.00	\$205	\$223	\$246
Kentucky	\$2,911,620	20,832	\$140	1.01	\$140	\$152	\$167
Louisiana	\$16,575,551	71,853	\$231	1.04	\$231	\$251	\$276
Maine	\$7,509,407	24,803	\$303	0.89	\$303	\$329	\$362
Maryland	\$4,568,734	19,107	\$239	1.21	\$239	\$260	\$286
Massachusetts	\$15,290,390	55,774	\$274	1.25	\$274	\$298	\$328
Michigan	\$3,989,439	45,551	\$88	0.96	\$88	\$95	\$105
Minnesota	\$2,575,836	16,527	\$156	1.09	\$156	\$170	\$187
Mississippi	\$6,169,987	39,262	\$157	1.19	\$157	\$171	\$188
Missouri	\$10,308,070	43,288	\$238	0.76	\$238	\$259	\$285
Montana	\$1,554,096	7,117	\$218	1.13	\$218	\$238	\$261
Nebraska	\$4,408,980	20,741	\$213	1.22	\$213	\$231	\$254
Nevada	\$1,367,850	4,908	\$279	1.43	\$279	\$303	\$333
New Hampshire	\$1,700,876	7,398	\$230	1.03	\$230	\$250	\$275
New Jersey	\$3,473,331	19,839	\$175	0.56	\$175	\$190	\$210
New Mexico	\$5,547,575	20,026	\$277	1.31	\$277	\$301	\$331
New York	\$59,697,682	274,019	\$218	0.70	\$218	\$237	\$261
North Carolina	\$31,660,637	101,800	\$311	1.34	\$311	\$338	\$372
North Dakota	\$1,426,725	6,164	\$231	1.23	\$231	\$252	\$277
Ohio	\$26,821,532	71,302	\$376	0.97	\$376	\$409	\$450
Oklahoma	\$3,012,463	16,672	\$181	0.95	\$181	\$197	\$216
Oregon	\$3,688,877	18,162	\$203	1.18	\$203	\$221	\$243
Pennsylvania	\$5,025,974	27,248	\$184	0.74	\$184	\$201	\$221
Rhode Island*	\$249,649	337	\$741	0.62	\$133	\$145	\$159
South Carolina*	\$72,194,656	135,957	\$531	1.17	\$251	\$273	\$300
South Dakota	\$1,323,323	7,202	\$184	1.05	\$184	\$200	\$220
Tennessee*	\$591,439	5,641	\$105	–	\$215	\$233	\$257
Texas	\$30,394,306	174,837	\$174	0.99	\$174	\$189	\$208
Utah	\$1,250,419	8,960	\$140	1.01	\$140	\$152	\$167
Vermont	\$2,215,266	12,228	\$181	1.12	\$181	\$197	\$217
Virginia	\$3,120,300	9,810	\$318	1.08	\$318	\$346	\$381
Washington	\$15,841,409	85,869	\$184	1.24	\$184	\$201	\$221
West Virginia	\$957,915	13,059	\$73	1.21	\$73	\$80	\$88
Wisconsin	\$6,971,054	58,902	\$118	1.19	\$118	\$129	\$142
Wyoming	\$1,950,958	3,955	\$493	1.40	\$493	\$537	\$590
Column sources and formulas	ref. 32	ref. 32	col. 1 ÷ col. 2	ref. 30	col. 3 or (average (col. 3) * col. 4)	col. 5 * 1.09 (ref. 29)	col. 6 * 1.1

*Original data were substituted with estimates. Note: Estimates are based on the unweighted average of the remaining states' cost per user; if a weighted average had been used, the average (inflated by 10%) would have been \$232 in 2005 dollars.

TABLE A15. Key findings for Scenario 200, first full year

State	(1) No. of expansion participants	(2) No. of unintended pregnancies averted	(3) No. of abortions averted	(4) No. of unintended births averted	(5) No. of unintended Medicaid births averted	(6) Savings from unintended Medicaid births averted (in 000s)	(7) Spending on expansion services (in 000s)	(8) Net savings (in 000s)
U.S. total	2,608,900	376,500	151,700	179,600	171,900	\$1,782,500	\$659,300	\$1,123,200
Alabama*	16,800	2,400	1,000	1,200	300	\$2,800	\$3,800	-\$1,000
Alaska	7,500	1,100	400	500	500	\$11,900	\$2,700	\$9,200
Arizona	99,500	14,400	5,800	6,800	5,400	\$52,800	\$39,600	\$13,300
Colorado	68,600	9,900	4,000	4,700	4,700	\$48,100	\$39,500	\$8,700
Connecticut	30,600	4,400	1,800	2,100	2,100	\$25,400	\$5,900	\$19,500
Delaware	7,300	1,100	400	500	500	\$5,900	\$1,600	\$4,300
District of Columbia	6,900	1,000	400	500	500	\$5,200	\$1,400	\$3,800
Florida	267,500	38,600	15,600	18,400	18,400	\$188,500	\$24,500	\$164,000
Georgia	137,600	19,900	8,000	9,500	9,500	\$107,700	\$18,900	\$88,800
Hawaii	8,800	1,300	500	600	600	\$6,400	\$2,000	\$4,400
Idaho	22,700	3,300	1,300	1,600	1,200	\$14,200	\$3,700	\$10,400
Illinois	162,300	23,400	9,400	11,200	11,200	\$98,900	\$62,100	\$36,800
Indiana	85,400	12,300	5,000	5,900	5,200	\$51,300	\$18,000	\$33,300
Kansas	34,800	5,000	2,000	2,400	2,100	\$21,000	\$8,600	\$12,500
Kentucky	60,600	8,800	3,500	4,200	4,200	\$46,300	\$10,100	\$36,200
Louisiana	95,500	13,800	5,600	6,600	6,600	\$91,700	\$26,400	\$65,400
Maine	11,900	1,700	700	800	800	\$7,300	\$4,300	\$3,000
Maryland	63,500	9,200	3,700	4,400	4,400	\$54,000	\$18,200	\$35,800
Massachusetts	54,600	7,900	3,200	3,800	3,800	\$48,300	\$17,900	\$30,300
Michigan*	7,000	1,000	400	500	500	\$6,300	\$700	\$5,500
Mississippi*	3,100	500	200	200	200	\$1,300	\$600	\$700
Missouri	69,100	10,000	4,000	4,800	4,800	\$42,900	\$19,700	\$23,200
Montana	15,900	2,300	900	1,100	900	\$9,800	\$4,200	\$5,600
Nebraska	21,500	3,100	1,200	1,500	1,500	\$18,200	\$5,500	\$12,700
Nevada	43,900	6,300	2,600	3,000	2,400	\$30,200	\$14,600	\$15,600
New Hampshire	12,900	1,900	800	900	900	\$9,700	\$3,600	\$6,200
New Jersey	96,500	13,900	5,600	6,600	6,600	\$54,200	\$20,200	\$33,900
New Mexico*	2,800	400	200	200	200	\$1,900	\$900	\$1,000
North Carolina*	8,600	1,200	500	600	600	\$5,200	\$3,200	\$2,000
North Dakota	6,500	900	400	400	300	\$4,500	\$1,800	\$2,700
Ohio	131,000	18,900	7,600	9,000	7,900	\$81,500	\$59,000	\$22,600
Oklahoma*	4,300	600	300	300	300	\$2,600	\$900	\$1,700
Oregon*	4,100	600	200	300	300	\$2,200	\$1,000	\$1,200
Pennsylvania	147,700	21,300	8,600	10,200	10,200	\$49,300	\$32,600	\$16,600
Rhode Island	11,500	1,700	700	800	800	\$9,800	\$1,800	\$8,000
South Carolina*	4,300	600	300	300	300	\$2,900	\$1,300	\$1,600
South Dakota	9,300	1,300	500	600	500	\$5,400	\$2,000	\$3,400
Tennessee	56,500	8,200	3,300	3,900	3,900	\$42,600	\$14,500	\$28,100
Texas	541,100	78,100	31,500	37,200	37,200	\$413,200	\$112,600	\$300,600
Utah	29,300	4,200	1,700	2,000	1,500	\$14,800	\$4,900	\$9,900
Vermont	4,600	700	300	300	300	\$3,600	\$1,000	\$2,600
Virginia	94,600	13,700	5,500	6,500	5,700	\$53,200	\$36,000	\$17,200
West Virginia	29,100	4,200	1,700	2,000	1,800	\$21,700	\$2,600	\$19,200
Wisconsin*	3,200	500	200	200	200	\$2,200	\$500	\$1,700
Wyoming	7,700	1,100	400	500	400	\$5,800	\$4,600	\$1,200
Column sources and formulas	(A8-col. 1 or A8-col. 4) * 60.22%	0.1443 * col. 1	0.403 * col. 2	0.477 * col. 2	0.477 * 0.1443 * ((A11-col. 4 or A11-col. 6) * 60.22%)	col. 5 * A13-col. 10	col. 1 * A14-col. 6	col. 6 - col. 7

*This state has an existing expansion; these findings are estimates of the additional participation and impact that would result under the scenario.
Note: States not included in this table have existing Medicaid family planning expansions for women with incomes up to at least the eligibility level anticipated under this scenario; the scenario would result in no new participation in these states.

TABLE A16. Key findings for Scenario 200 Optional, first full year

State	(1) No. of expansion participants	(2) No. of unintended pregnancies averted	(3) No. of abortions averted	(4) No. of unintended births averted	(5) No. of unintended Medicaid births averted	(6) Savings from unintended Medicaid births averted (in 000s)	(7) Spending on expansion services (in 000s)	(8) Net savings (in 000s)
U.S. total	1,875,700	270,700	109,100	129,100	125,800	\$1,272,100	\$453,100	\$819,000
Arizona	99,500	14,400	5,800	6,800	5,400	\$52,800	\$39,600	\$13,300
Connecticut	30,600	4,400	1,800	2,100	2,100	\$25,400	\$5,900	\$19,500
Delaware	7,300	1,100	400	500	500	\$5,900	\$1,600	\$4,300
Florida	267,500	38,600	15,600	18,400	18,400	\$188,500	\$24,500	\$164,000
Hawaii	8,800	1,300	500	600	600	\$6,400	\$2,000	\$4,400
Illinois	162,300	23,400	9,400	11,200	11,200	\$98,900	\$62,100	\$36,800
Indiana	85,400	12,300	5,000	5,900	5,200	\$51,300	\$18,000	\$33,300
Louisiana	95,500	13,800	5,600	6,600	6,600	\$91,700	\$26,400	\$65,400
Maine	11,900	1,700	700	800	800	\$7,300	\$4,300	\$3,000
Maryland	63,500	9,200	3,700	4,400	4,400	\$54,000	\$18,200	\$35,800
Massachusetts	54,600	7,900	3,200	3,800	3,800	\$48,300	\$17,900	\$30,300
Missouri	69,100	10,000	4,000	4,800	4,800	\$42,900	\$19,700	\$23,200
Montana	15,900	2,300	900	1,100	900	\$9,800	\$4,200	\$5,600
New Jersey	96,500	13,900	5,600	6,600	6,600	\$54,200	\$20,200	\$33,900
Pennsylvania	147,700	21,300	8,600	10,200	10,200	\$49,300	\$32,600	\$16,600
Rhode Island	11,500	1,700	700	800	800	\$9,800	\$1,800	\$8,000
Texas	541,100	78,100	31,500	37,200	37,200	\$413,200	\$112,600	\$300,600
Vermont	4,600	700	300	300	300	\$3,600	\$1,000	\$2,600
Virginia	94,600	13,700	5,500	6,500	5,700	\$53,200	\$36,000	\$17,200
Wyoming	7,700	1,100	400	500	400	\$5,800	\$4,600	\$1,200
Column sources and formulas	A8-col. 1 * 60.22%	0.1443 * col. 1	0.403 * col. 2	0.477 * col. 2	0.477 * 0.1443 * (A11- col. 4 * 60.22%)	col. 5 * A13-col. 10	col. 1 * A14-col. 6	col. 6 – col. 7

TABLE A17. Key findings for Scenario 250, first full year

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
State	No. of expansion participants	No. of unintended pregnancies averted	No. of abortions averted	No. of unintended births averted	No. of unintended Medicaid births averted	Savings from unintended Medicaid births averted (in 000s)	Spending on expansion services (in 000s)	Net savings (in 000s)
U.S. total	3,613,500	521,500	210,200	248,700	195,800	\$2,030,400	\$904,400	\$1,126,100
Alabama*	30,500	4,400	1,800	2,100	300	\$2,800	\$6,800	-\$4,100
Alaska	9,400	1,400	500	600	500	\$11,900	\$3,300	\$8,600
Arizona	120,300	17,400	7,000	8,300	5,400	\$52,800	\$47,900	\$5,000
Arkansas*	10,900	1,600	600	800	400	\$4,700	\$2,800	\$1,800
California*	135,700	19,600	7,900	9,300	5,400	\$46,300	\$27,600	\$18,700
Colorado	87,100	12,600	5,100	6,000	5,500	\$55,600	\$50,100	\$5,500
Connecticut	37,400	5,400	2,200	2,600	2,200	\$26,800	\$7,200	\$19,500
Delaware	9,500	1,400	600	700	600	\$6,900	\$2,100	\$4,800
District of Columbia	8,300	1,200	500	600	500	\$5,800	\$1,700	\$4,200
Florida	332,800	48,000	19,400	22,900	19,500	\$199,200	\$30,500	\$168,700
Georgia	175,500	25,300	10,200	12,100	11,000	\$124,800	\$24,100	\$100,700
Hawaii	11,000	1,600	600	800	600	\$6,700	\$2,500	\$4,200
Idaho	28,700	4,100	1,700	2,000	1,200	\$14,200	\$4,700	\$9,400
Illinois	198,900	28,700	11,600	13,700	12,600	\$111,800	\$76,100	\$35,700
Indiana	106,100	15,300	6,200	7,300	5,200	\$51,300	\$22,400	\$28,900
Iowa*	9,000	1,300	500	600	400	\$5,000	\$1,800	\$3,200
Kansas	43,900	6,300	2,600	3,000	2,100	\$21,000	\$10,800	\$10,200
Kentucky	74,100	10,700	4,300	5,100	4,400	\$48,700	\$12,400	\$36,300
Louisiana	114,300	16,500	6,600	7,900	7,300	\$102,200	\$31,600	\$70,600
Maine	14,500	2,100	800	1,000	900	\$8,300	\$5,200	\$3,000
Maryland	81,900	11,800	4,800	5,600	5,600	\$69,500	\$23,400	\$46,100
Massachusetts	66,000	9,500	3,800	4,500	4,200	\$54,100	\$21,700	\$32,400
Michigan*	32,200	4,700	1,900	2,200	900	\$11,600	\$3,400	\$8,200
Minnesota*	11,400	1,600	700	800	800	\$9,600	\$2,100	\$7,400
Mississippi*	13,900	2,000	800	1,000	400	\$2,300	\$2,600	-\$300
Missouri	86,800	12,500	5,000	6,000	5,000	\$45,500	\$24,700	\$20,700
Montana	19,200	2,800	1,100	1,300	900	\$9,800	\$5,000	\$4,800
Nebraska	27,700	4,000	1,600	1,900	1,600	\$19,400	\$7,000	\$12,300
Nevada	54,400	7,800	3,200	3,700	2,400	\$30,200	\$18,100	\$12,100
New Hampshire	17,100	2,500	1,000	1,200	1,000	\$10,400	\$4,700	\$5,700
New Jersey	120,300	17,400	7,000	8,300	7,600	\$61,900	\$25,200	\$36,700
New Mexico*	11,100	1,600	600	800	300	\$3,200	\$3,700	-\$500
New York*	57,200	8,300	3,300	3,900	2,300	\$29,200	\$14,900	\$14,300
North Carolina*	42,600	6,200	2,500	2,900	1,100	\$10,000	\$15,900	-\$5,900
North Dakota	8,000	1,200	500	600	300	\$4,500	\$2,200	\$2,200
Ohio	163,800	23,600	9,500	11,300	7,900	\$81,500	\$73,700	\$7,800
Oklahoma*	19,000	2,700	1,100	1,300	500	\$4,700	\$4,100	\$600
Oregon*	18,100	2,600	1,100	1,200	500	\$4,000	\$4,400	-\$400
Pennsylvania	182,100	26,300	10,600	12,500	10,700	\$51,900	\$40,200	\$11,700
Rhode Island	13,900	2,000	800	1,000	1,000	\$11,900	\$2,200	\$9,700
South Carolina*	21,100	3,000	1,200	1,500	600	\$5,600	\$6,300	-\$800
South Dakota	11,200	1,600	700	800	500	\$5,400	\$2,500	\$2,900
Tennessee	69,900	10,100	4,100	4,800	4,100	\$45,000	\$18,000	\$27,000
Texas	663,500	95,700	38,600	45,700	39,200	\$435,000	\$138,000	\$297,000
Utah	38,600	5,600	2,200	2,700	1,500	\$14,800	\$6,400	\$8,300
Vermont	5,800	800	300	400	400	\$4,100	\$1,300	\$2,900
Virginia	121,200	17,500	7,100	8,300	5,700	\$53,200	\$46,100	\$7,000
Washington*	18,100	2,600	1,100	1,200	300	\$3,900	\$4,000	-\$100
West Virginia	35,100	5,100	2,000	2,400	1,800	\$21,700	\$3,100	\$18,600
Wisconsin*	15,100	2,200	900	1,000	400	\$4,100	\$2,100	\$1,900
Wyoming	9,500	1,400	600	700	400	\$5,800	\$5,600	\$200
Column sources and formulas	(A8-col. 2 or A8-col. 5) * 60.22%	0.1443 * col. 1	0.403 * col. 2	0.477 * col. 2	0.477 * 0.1443 * ((A11-col. 5 or A11-col. 7) * 60.22%)	col. 5 * A13-col. 10	col. 1 * A14-col. 6	col. 6 - col. 7

*This state has an existing expansion; these findings are estimates of the additional participation and impact that would result under the scenario.

TABLE A18. Key findings for Scenario Pregnancy Care, first full year

State	(1) No. of expansion participants	(2) No. of unintended pregnancies averted	(3) No. of abortions averted	(4)/(5) No. of unintended births/ Medicaid births averted	(6) Savings from unintended Medicaid births averted (in 000s)	(7) Spending on expansion services (in 000s)	(8) Net savings (in 000s)
U.S. total	2,355,800	340,000	137,000	162,200	\$1,689,900	\$589,000	\$1,100,800
Alaska	6,600	1,000	400	500	\$10,500	\$2,400	\$8,100
Arizona	71,000	10,200	4,100	4,900	\$47,400	\$28,200	\$19,100
Colorado	68,600	9,900	4,000	4,700	\$48,100	\$39,500	\$8,700
Connecticut	28,800	4,200	1,700	2,000	\$23,900	\$5,600	\$18,400
Delaware	7,300	1,100	400	500	\$5,900	\$1,600	\$4,300
District of Columbia	6,900	1,000	400	500	\$5,200	\$1,400	\$3,800
Florida	250,500	36,100	14,600	17,200	\$176,400	\$23,000	\$153,500
Georgia	137,600	19,900	8,000	9,500	\$107,700	\$18,900	\$88,800
Hawaii	8,100	1,200	500	600	\$5,900	\$1,800	\$4,100
Idaho	14,400	2,100	800	1,000	\$12,200	\$2,400	\$9,800
Illinois	162,300	23,400	9,400	11,200	\$98,900	\$62,100	\$36,800
Indiana	67,000	9,700	3,900	4,600	\$45,900	\$14,200	\$31,700
Kansas	26,100	3,800	1,500	1,800	\$18,400	\$6,400	\$12,000
Kentucky	56,900	8,200	3,300	3,900	\$43,500	\$9,500	\$34,000
Louisiana	95,500	13,800	5,600	6,600	\$91,700	\$26,400	\$65,400
Maine	11,900	1,700	700	800	\$7,300	\$4,300	\$3,000
Maryland	81,900	11,800	4,800	5,600	\$69,500	\$23,400	\$46,100
Massachusetts	54,600	7,900	3,200	3,800	\$48,300	\$17,900	\$30,300
Minnesota*	17,100	2,500	1,000	1,200	\$14,300	\$3,200	\$11,100
Missouri	64,200	9,300	3,700	4,400	\$39,800	\$18,300	\$21,500
Montana	11,100	1,600	600	800	\$8,700	\$2,900	\$5,800
Nebraska	19,800	2,900	1,200	1,400	\$16,700	\$5,000	\$11,700
Nevada	31,200	4,500	1,800	2,100	\$27,100	\$10,400	\$16,700
New Hampshire	11,900	1,700	700	800	\$9,000	\$3,300	\$5,700
New Jersey	96,500	13,900	5,600	6,600	\$54,200	\$20,200	\$33,900
North Dakota	4,400	600	300	300	\$3,900	\$1,200	\$2,700
Ohio	101,400	14,600	5,900	7,000	\$72,400	\$45,600	\$26,700
Pennsylvania	138,500	20,000	8,100	9,500	\$46,200	\$30,600	\$15,600
Rhode Island	13,900	2,000	800	1,000	\$11,900	\$2,200	\$9,700
South Dakota	6,700	1,000	400	500	\$4,900	\$1,500	\$3,400
Tennessee	53,000	7,700	3,100	3,700	\$40,000	\$13,600	\$26,300
Texas	505,800	73,000	29,400	34,800	\$386,300	\$105,200	\$281,000
Utah	18,600	2,700	1,100	1,300	\$12,700	\$3,100	\$9,600
Vermont	4,600	700	300	300	\$3,600	\$1,000	\$2,600
Virginia	72,800	10,500	4,200	5,000	\$47,100	\$27,700	\$19,400
West Virginia	23,100	3,300	1,300	1,600	\$19,500	\$2,000	\$17,500
Wyoming	5,300	800	300	400	\$5,100	\$3,100	\$2,000
Column sources and formulas	(A8-col. 3 or A8-col. 6) * 60.22%	0.1443 * col. 1	0.403 * col. 2	0.477 * col. 2	col. 5 * A13-col. 10	col. 1 * A14-col. 6	col. 6 – col. 7

*This state has an existing expansion; these findings are estimates of the additional participation and impact that would result under the scenario. *Note:* States not included in this table have existing Medicaid family planning expansions for women with incomes up to at least the eligibility level anticipated under this scenario; the scenario would result in no new participation in these states.

TABLE A19. Key findings for Scenario 200, 100% participation

State	(1) No. of expansion participants	(2) No. of unintended pregnancies averted	(3) No. of abortions averted	(4) No. of unintended births averted	(5) No. of unintended Medicaid births averted	(6) Savings from unintended Medicaid births averted (in 000s)	(7) Spending on expansion services (in 000s)	(8) Net savings (in 000s)
U.S. total	4,332,300	625,200	252,000	298,200	285,500	\$2,960,000	\$1,094,800	\$1,865,100
Alabama*	28,000	4,000	1,600	1,900	600	\$4,600	\$6,300	-\$1,700
Alaska	12,500	1,800	700	900	900	\$19,700	\$4,400	\$15,300
Arizona	165,200	23,800	9,600	11,400	9,000	\$87,700	\$65,700	\$22,000
Colorado	113,900	16,400	6,600	7,800	7,800	\$79,900	\$65,500	\$14,400
Connecticut	50,900	7,300	3,000	3,500	3,500	\$42,200	\$9,800	\$32,400
Delaware	12,100	1,800	700	800	800	\$9,700	\$2,600	\$7,100
District of Columbia	11,500	1,700	700	800	800	\$8,700	\$2,300	\$6,400
Florida	444,300	64,100	25,800	30,600	30,600	\$313,000	\$40,700	\$272,300
Georgia	228,400	33,000	13,300	15,700	15,700	\$178,800	\$31,300	\$147,500
Hawaii	14,600	2,100	800	1,000	1,000	\$10,600	\$3,300	\$7,300
Idaho	37,600	5,400	2,200	2,600	1,900	\$23,500	\$6,200	\$17,300
Illinois	269,500	38,900	15,700	18,600	18,600	\$164,300	\$103,100	\$61,200
Indiana	141,800	20,500	8,200	9,800	8,600	\$85,200	\$30,000	\$55,200
Kansas	57,800	8,300	3,400	4,000	3,400	\$34,900	\$14,200	\$20,700
Kentucky	100,700	14,500	5,900	6,900	6,900	\$76,900	\$16,800	\$60,100
Louisiana	158,500	22,900	9,200	10,900	10,900	\$152,300	\$43,800	\$108,600
Maine	19,800	2,900	1,200	1,400	1,400	\$12,200	\$7,200	\$5,000
Maryland	105,500	15,200	6,100	7,300	7,300	\$89,600	\$30,200	\$59,400
Massachusetts	90,700	13,100	5,300	6,200	6,200	\$80,100	\$29,800	\$50,400
Michigan*	11,600	1,700	700	800	800	\$10,400	\$1,200	\$9,200
Mississippi*	5,200	800	300	400	400	\$2,100	\$1,000	\$1,100
Missouri	114,800	16,600	6,700	7,900	7,900	\$71,200	\$32,700	\$38,500
Montana	26,500	3,800	1,500	1,800	1,400	\$16,200	\$6,900	\$9,300
Nebraska	35,700	5,100	2,100	2,500	2,500	\$30,100	\$9,100	\$21,100
Nevada	72,900	10,500	4,200	5,000	4,000	\$50,200	\$24,300	\$25,900
New Hampshire	21,400	3,100	1,200	1,500	1,500	\$16,100	\$5,900	\$10,200
New Jersey	160,300	23,100	9,300	11,000	11,000	\$89,900	\$33,600	\$56,400
New Mexico*	4,700	700	300	300	300	\$3,100	\$1,600	\$1,600
North Carolina*	14,300	2,100	800	1,000	1,000	\$8,600	\$5,300	\$3,300
North Dakota	10,800	1,600	600	700	600	\$7,400	\$3,000	\$4,400
Ohio	217,600	31,400	12,700	15,000	13,100	\$135,400	\$98,000	\$37,400
Oklahoma*	7,200	1,000	400	500	500	\$4,400	\$1,600	\$2,800
Oregon*	6,800	1,000	400	500	500	\$3,700	\$1,600	\$2,000
Pennsylvania	245,300	35,400	14,300	16,900	16,900	\$81,800	\$54,100	\$27,600
Rhode Island	19,000	2,700	1,100	1,300	1,300	\$16,300	\$3,000	\$13,300
South Carolina*	7,200	1,000	400	500	500	\$4,800	\$2,200	\$2,700
South Dakota	15,400	2,200	900	1,100	800	\$9,000	\$3,400	\$5,600
Tennessee	93,800	13,500	5,500	6,500	6,500	\$70,700	\$24,100	\$46,600
Texas	898,500	129,700	52,300	61,800	61,800	\$686,100	\$186,900	\$499,200
Utah	48,700	7,000	2,800	3,400	2,500	\$24,600	\$8,100	\$16,400
Vermont	7,700	1,100	400	500	500	\$5,900	\$1,700	\$4,300
Virginia	157,100	22,700	9,100	10,800	9,400	\$88,300	\$59,800	\$28,500
West Virginia	48,400	7,000	2,800	3,300	2,900	\$36,100	\$4,200	\$31,800
Wisconsin*	5,300	800	300	400	400	\$3,600	\$700	\$2,900
Wyoming	12,800	1,900	700	900	700	\$9,600	\$7,600	\$2,100
Column sources and formulas	A8-col. 1 or A8-col. 4	0.1443 * col. 1	0.403 * col. 2	0.477 * col. 2	0.477 * 0.1443 * (A11-col. 4 or A11-col. 6)	col. 5 * A13-col. 10	col. 1 * A14-col. 6	col. 6 – col. 7

*This state has an existing expansion; these findings are estimates of the additional participation and impact that would result under the scenario. *Note:* States not included in this table have existing Medicaid family planning expansions for women with incomes up to at least the eligibility level anticipated under this scenario; the scenario would result in no new participation in these states.

TABLE A20. Key findings for Scenario 200 Optional, 100% participation

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
State	No. of expansion participants	No. of unintended pregnancies averted	No. of abortions averted	No. of unintended births averted	No. of unintended Medicaid births averted	Savings from unintended Medicaid births averted (in 000s)	Spending on expansion services (in 000s)	Net savings (in 000s)
U.S. total	3,114,800	449,500	181,100	214,400	208,900	\$2,112,500	\$752,500	\$1,360,000
Arizona	165,200	23,800	9,600	11,400	9,000	\$87,700	\$65,700	\$22,000
Connecticut	50,900	7,300	3,000	3,500	3,500	\$42,200	\$9,800	\$32,400
Delaware	12,100	1,800	700	800	800	\$9,700	\$2,600	\$7,100
Florida	444,300	64,100	25,800	30,600	30,600	\$313,000	\$40,700	\$272,300
Hawaii	14,600	2,100	800	1,000	1,000	\$10,600	\$3,300	\$7,300
Illinois	269,500	38,900	15,700	18,600	18,600	\$164,300	\$103,100	\$61,200
Indiana	141,800	20,500	8,200	9,800	8,600	\$85,200	\$30,000	\$55,200
Louisiana	158,500	22,900	9,200	10,900	10,900	\$152,300	\$43,800	\$108,600
Maine	19,800	2,900	1,200	1,400	1,400	\$12,200	\$7,200	\$5,000
Maryland	105,500	15,200	6,100	7,300	7,300	\$89,600	\$30,200	\$59,400
Massachusetts	90,700	13,100	5,300	6,200	6,200	\$80,100	\$29,800	\$50,400
Missouri	114,800	16,600	6,700	7,900	7,900	\$71,200	\$32,700	\$38,500
Montana	26,500	3,800	1,500	1,800	1,400	\$16,200	\$6,900	\$9,300
New Jersey	160,300	23,100	9,300	11,000	11,000	\$89,900	\$33,600	\$56,400
Pennsylvania	245,300	35,400	14,300	16,900	16,900	\$81,800	\$54,100	\$27,600
Rhode Island	19,000	2,700	1,100	1,300	1,300	\$16,300	\$3,000	\$13,300
Texas	898,500	129,700	52,300	61,800	61,800	\$686,100	\$186,900	\$499,200
Vermont	7,700	1,100	400	500	500	\$5,900	\$1,700	\$4,300
Virginia	157,100	22,700	9,100	10,800	9,400	\$88,300	\$59,800	\$28,500
Wyoming	12,800	1,900	700	900	700	\$9,600	\$7,600	\$2,100
Column sources and formulas	A8-col. 1	0.1443 * col. 1	0.403 * col. 2	0.477 * col. 2	0.477 * 0.1443 * A11-col. 4	col. 5 * A13-col. 10	col. 1 * A14-col. 6	col. 6 – col. 7

TABLE A21. Key findings for Scenario 250, 100% participation

State	(1) No. of expansion participants	(2) No. of unintended pregnancies averted	(3) No. of abortions averted	(4) No. of unintended births averted	(5) No. of unintended Medicaid births averted	(6) Savings from unintended Medicaid births averted (in 000s)	(7) Spending on expansion services (in 000s)	(8) Net savings (in 000s)
U.S. total	6,000,600	865,900	349,000	413,100	325,100	\$3,371,700	\$1,501,800	\$1,870,000
Alabama*	50,700	7,300	2,900	3,500	600	\$4,600	\$11,300	-\$6,700
Alaska	15,600	2,300	900	1,100	900	\$19,800	\$5,500	\$14,200
Arizona	199,700	28,800	11,600	13,700	9,000	\$87,700	\$79,500	\$8,300
Arkansas*	18,100	2,600	1,100	1,200	700	\$7,700	\$4,700	\$3,000
California*	225,300	32,500	13,100	15,500	9,000	\$76,900	\$45,800	\$31,100
Colorado	144,600	20,900	8,400	10,000	9,100	\$92,400	\$83,200	\$9,100
Connecticut	62,200	9,000	3,600	4,300	3,700	\$44,400	\$12,000	\$32,400
Delaware	15,800	2,300	900	1,100	1,000	\$11,400	\$3,400	\$8,000
District of Columbia	13,700	2,000	800	900	900	\$9,700	\$2,800	\$6,900
Florida	552,700	79,800	32,100	38,000	32,300	\$330,800	\$50,600	\$280,200
Georgia	291,400	42,100	16,900	20,100	18,200	\$207,300	\$40,000	\$167,300
Hawaii	18,200	2,600	1,100	1,300	1,100	\$11,200	\$4,100	\$7,000
Idaho	47,700	6,900	2,800	3,300	1,900	\$23,500	\$7,900	\$15,700
Illinois	330,400	47,700	19,200	22,700	21,000	\$185,700	\$126,400	\$59,300
Indiana	176,100	25,400	10,200	12,100	8,600	\$85,200	\$37,200	\$48,000
Iowa*	14,900	2,200	900	1,000	600	\$8,300	\$3,000	\$5,300
Kansas	72,900	10,500	4,200	5,000	3,400	\$34,900	\$17,900	\$17,000
Kentucky	123,000	17,700	7,200	8,500	7,300	\$80,900	\$20,600	\$60,400
Louisiana	189,800	27,400	11,000	13,100	12,200	\$169,700	\$52,400	\$117,300
Maine	24,000	3,500	1,400	1,700	1,500	\$13,700	\$8,700	\$5,000
Maryland	135,900	19,600	7,900	9,400	9,400	\$115,500	\$38,900	\$76,600
Massachusetts	109,600	15,800	6,400	7,500	7,000	\$89,800	\$36,000	\$53,800
Michigan*	53,500	7,700	3,100	3,700	1,500	\$19,200	\$5,600	\$13,600
Minnesota*	18,900	2,700	1,100	1,300	1,300	\$15,900	\$3,500	\$12,300
Mississippi*	23,100	3,300	1,300	1,600	600	\$3,800	\$4,300	-\$500
Missouri	144,100	20,800	8,400	9,900	8,400	\$75,500	\$41,100	\$34,400
Montana	31,800	4,600	1,900	2,200	1,400	\$16,200	\$8,300	\$7,900
Nebraska	46,000	6,600	2,700	3,200	2,600	\$32,200	\$11,700	\$20,500
Nevada	90,300	13,000	5,300	6,200	4,000	\$50,200	\$30,100	\$20,100
New Hampshire	28,400	4,100	1,700	2,000	1,600	\$17,300	\$7,800	\$9,500
New Jersey	199,800	28,800	11,600	13,800	12,600	\$102,700	\$41,900	\$60,900
New Mexico*	18,400	2,700	1,100	1,300	500	\$5,300	\$6,100	-\$800
New York*	95,000	13,700	5,500	6,500	3,800	\$48,500	\$24,800	\$23,800
North Carolina*	70,800	10,200	4,100	4,900	1,900	\$16,600	\$26,300	-\$9,800
North Dakota	13,300	1,900	800	900	600	\$7,400	\$3,700	\$3,700
Ohio	272,000	39,300	15,800	18,700	13,100	\$135,400	\$122,400	\$13,000
Oklahoma*	31,500	4,500	1,800	2,200	900	\$7,800	\$6,800	\$1,000
Oregon*	30,000	4,300	1,700	2,100	800	\$6,600	\$7,300	-\$700
Pennsylvania	302,500	43,600	17,600	20,800	17,800	\$86,200	\$66,800	\$19,500
Rhode Island	23,000	3,300	1,300	1,600	1,600	\$19,700	\$3,700	\$16,100
South Carolina*	35,000	5,000	2,000	2,400	900	\$9,300	\$10,500	-\$1,300
South Dakota	18,600	2,700	1,100	1,300	800	\$9,000	\$4,100	\$4,900
Tennessee	116,100	16,800	6,800	8,000	6,800	\$74,600	\$29,800	\$44,800
Texas	1,101,800	159,000	64,100	75,800	65,100	\$722,400	\$229,200	\$493,200
Utah	64,100	9,300	3,700	4,400	2,500	\$24,600	\$10,700	\$13,900
Vermont	9,600	1,400	600	700	600	\$6,800	\$2,100	\$4,700
Virginia	201,300	29,100	11,700	13,900	9,400	\$88,300	\$76,600	\$11,700
Washington*	30,100	4,300	1,700	2,100	500	\$6,400	\$6,600	-\$200
West Virginia	58,200	8,400	3,400	4,000	2,900	\$36,100	\$5,100	\$30,900
Wisconsin*	25,100	3,600	1,500	1,700	700	\$6,800	\$3,600	\$3,200
Wyoming	15,700	2,300	900	1,100	700	\$9,600	\$9,300	\$400
Column sources and formulas	A8-col. 2 or A8-col. 5	0.1443 * col. 1	0.403 * col. 2	0.477 * col. 2	0.477 * 0.1443 * (A11-col. 5 or A11-col. 7)	col. 5 * A13-col. 10	col. 1 * A14-col. 6	col. 6 – col. 7

*This state has an existing expansion; these findings are estimates of the additional participation and impact that would result under the scenario.

TABLE A22. Key findings for Scenario Pregnancy Care, 100% participation

State	(1) No. of expansion participants	(2) No. of unintended pregnancies averted	(3) No. of abortions averted	(4)/(5) No. of unintended births/ Medicaid births averted	(6) Savings from unintended Medicaid births averted (in 000s)	(7) Spending on expansion services (in 000s)	(8) Net savings (in 000s)
U.S. total	3,912,100	564,600	227,500	269,300	\$2,806,200	\$978,200	\$1,828,000
Alaska	11,000	1,600	600	800	\$17,400	\$3,900	\$13,500
Arizona	117,900	17,000	6,900	8,100	\$78,700	\$46,900	\$31,800
Colorado	113,900	16,400	6,600	7,800	\$79,900	\$65,500	\$14,400
Connecticut	47,900	6,900	2,800	3,300	\$39,700	\$9,200	\$30,500
Delaware	12,100	1,800	700	800	\$9,700	\$2,600	\$7,100
District of Columbia	11,500	1,700	700	800	\$8,700	\$2,300	\$6,400
Florida	415,900	60,000	24,200	28,600	\$293,000	\$38,100	\$254,900
Georgia	228,400	33,000	13,300	15,700	\$178,800	\$31,300	\$147,500
Hawaii	13,500	1,900	800	900	\$9,800	\$3,100	\$6,700
Idaho	23,900	3,400	1,400	1,600	\$20,200	\$3,900	\$16,300
Illinois	269,500	38,900	15,700	18,600	\$164,300	\$103,100	\$61,200
Indiana	111,200	16,000	6,500	7,700	\$76,100	\$23,500	\$52,600
Kansas	43,400	6,300	2,500	3,000	\$30,500	\$10,700	\$19,900
Kentucky	94,500	13,600	5,500	6,500	\$72,200	\$15,800	\$56,400
Louisiana	158,500	22,900	9,200	10,900	\$152,300	\$43,800	\$108,600
Maine	19,800	2,900	1,200	1,400	\$12,200	\$7,200	\$5,000
Maryland	135,900	19,600	7,900	9,400	\$115,500	\$38,900	\$76,600
Massachusetts	90,700	13,100	5,300	6,200	\$80,100	\$29,800	\$50,400
Minnesota*	28,400	4,100	1,700	2,000	\$23,800	\$5,300	\$18,500
Missouri	106,700	15,400	6,200	7,300	\$66,200	\$30,400	\$35,800
Montana	18,500	2,700	1,100	1,300	\$14,400	\$4,800	\$9,600
Nebraska	32,800	4,700	1,900	2,300	\$27,800	\$8,400	\$19,400
Nevada	51,800	7,500	3,000	3,600	\$45,000	\$17,300	\$27,700
New Hampshire	19,800	2,900	1,100	1,400	\$14,900	\$5,400	\$9,400
New Jersey	160,300	23,100	9,300	11,000	\$89,900	\$33,600	\$56,400
North Dakota	7,300	1,000	400	500	\$6,500	\$2,000	\$4,500
Ohio	168,400	24,300	9,800	11,600	\$120,200	\$75,800	\$44,400
Pennsylvania	229,900	33,200	13,400	15,800	\$76,700	\$50,700	\$25,900
Rhode Island	23,000	3,300	1,300	1,600	\$19,700	\$3,700	\$16,100
South Dakota	11,100	1,600	600	800	\$8,100	\$2,400	\$5,600
Tennessee	88,100	12,700	5,100	6,100	\$66,400	\$22,600	\$43,800
Texas	840,000	121,200	48,900	57,800	\$641,400	\$174,700	\$466,700
Utah	30,800	4,400	1,800	2,100	\$21,100	\$5,100	\$15,900
Vermont	7,700	1,100	400	500	\$5,900	\$1,700	\$4,300
Virginia	120,900	17,400	7,000	8,300	\$78,200	\$46,000	\$32,100
West Virginia	38,400	5,500	2,200	2,600	\$32,400	\$3,400	\$29,000
Wyoming	8,800	1,300	500	600	\$8,500	\$5,200	\$3,300
Column sources and formulas	A8-col. 3 or A8-col. 6	0.1443 * col. 1	0.403 * col. 2	0.477 * col. 2	col. 5 * A13-col. 10	col. 1 * A14-col. 6	col. 6 – col. 7

*This state has an existing expansion; these findings are estimates of the additional participation and impact that would result under the scenario. *Note:* States not included in this table have existing Medicaid family planning expansions for women with incomes up to at least the eligibility level anticipated under this scenario; the scenario would result in no new participation in these states.

TABLE A23. Federal and state costs and savings for Scenario 200, third full year

State	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	2005 federal medical assistance percentage	Federal proportion			State proportion		
		Savings from unintended Medicaid births averted (in 000s)	Spending on expansion services (in 000s)	Net savings (in 000s)	Savings from unintended Medicaid births averted (in 000s)	Spending on expansion services (in 000s)	Net savings (in 000s)
U.S. total	–	\$1,468,100	\$789,100	\$679,000	\$1,002,100	\$124,600	\$877,500
Alabama*	70.83	\$2,700	\$4,500	-\$1,800	\$1,100	\$700	\$400
Alaska	57.58	\$9,500	\$3,200	\$6,300	\$7,000	\$500	\$6,500
Arizona	67.45	\$49,400	\$47,400	\$2,000	\$23,800	\$7,500	\$16,400
Colorado	50.00	\$33,300	\$47,200	-\$13,900	\$33,300	\$7,500	\$25,900
Connecticut	50.00	\$17,600	\$7,100	\$10,600	\$17,600	\$1,100	\$16,500
Delaware	50.38	\$4,100	\$1,900	\$2,200	\$4,000	\$300	\$3,700
District of Columbia	70.00	\$5,100	\$1,700	\$3,400	\$2,200	\$300	\$1,900
Florida	58.90	\$153,800	\$29,300	\$124,500	\$107,300	\$4,600	\$102,700
Georgia	60.44	\$90,200	\$22,600	\$67,600	\$59,000	\$3,600	\$55,500
Hawaii	58.47	\$5,200	\$2,400	\$2,800	\$3,700	\$400	\$3,300
Idaho	70.62	\$13,900	\$4,500	\$9,400	\$5,800	\$700	\$5,100
Illinois	50.00	\$68,600	\$74,300	-\$5,800	\$68,600	\$11,700	\$56,800
Indiana	62.78	\$44,600	\$21,600	\$23,000	\$26,500	\$3,400	\$23,100
Kansas	61.01	\$17,800	\$10,200	\$7,500	\$11,400	\$1,600	\$9,700
Kentucky	69.60	\$44,700	\$12,100	\$32,600	\$19,500	\$1,900	\$17,600
Louisiana	71.04	\$90,300	\$31,500	\$58,800	\$36,800	\$5,000	\$31,800
Maine	64.89	\$6,600	\$5,200	\$1,400	\$3,600	\$800	\$2,800
Maryland	50.00	\$37,400	\$21,800	\$15,600	\$37,400	\$3,400	\$34,000
Massachusetts	50.00	\$33,400	\$21,400	\$12,000	\$33,400	\$3,400	\$30,100
Michigan*	56.71	\$4,900	\$900	\$4,100	\$3,800	\$100	\$3,600
Mississippi*	77.08	\$1,400	\$700	\$700	\$400	\$100	\$300
Missouri	61.15	\$36,300	\$23,600	\$12,800	\$23,100	\$3,700	\$19,400
Montana	71.90	\$9,700	\$5,000	\$4,800	\$3,800	\$800	\$3,000
Nebraska	59.64	\$15,000	\$6,500	\$8,500	\$10,200	\$1,000	\$9,100
Nevada	55.90	\$23,400	\$17,500	\$5,900	\$18,500	\$2,800	\$15,700
New Hampshire	50.00	\$6,700	\$4,200	\$2,500	\$6,700	\$700	\$6,100
New Jersey	50.00	\$37,500	\$24,200	\$13,300	\$37,500	\$3,800	\$33,700
New Mexico*	74.30	\$2,000	\$1,100	\$800	\$700	\$200	\$500
North Carolina*	63.63	\$4,600	\$3,800	\$700	\$2,600	\$600	\$2,000
North Dakota	67.49	\$4,200	\$2,200	\$2,000	\$2,000	\$300	\$1,700
Ohio	59.68	\$67,400	\$70,600	-\$3,200	\$45,600	\$11,100	\$34,400
Oklahoma*	70.18	\$2,600	\$1,100	\$1,400	\$1,100	\$200	\$900
Oregon*	61.12	\$1,900	\$1,200	\$700	\$1,200	\$200	\$1,000
Pennsylvania	53.84	\$36,700	\$39,000	-\$2,300	\$31,500	\$6,200	\$25,300
Rhode Island	55.38	\$7,500	\$2,200	\$5,400	\$6,100	\$300	\$5,700
South Carolina*	69.89	\$2,800	\$1,600	\$1,300	\$1,200	\$200	\$1,000
South Dakota	66.03	\$4,900	\$2,400	\$2,500	\$2,500	\$400	\$2,200
Tennessee	64.81	\$38,200	\$17,400	\$20,900	\$20,800	\$2,700	\$18,000
Texas	60.87	\$348,500	\$134,700	\$213,800	\$224,000	\$21,300	\$202,800
Utah	72.14	\$14,800	\$5,900	\$8,900	\$5,700	\$900	\$4,800
Vermont	60.11	\$3,000	\$1,200	\$1,800	\$2,000	\$200	\$1,800
Virginia	50.00	\$36,800	\$43,100	-\$6,300	\$36,800	\$6,800	\$30,000
West Virginia	74.65	\$22,500	\$3,100	\$19,400	\$7,600	\$500	\$7,100
Wisconsin*	58.32	\$1,800	\$500	\$1,200	\$1,300	\$100	\$1,200
Wyoming	57.90	\$4,700	\$5,500	-\$800	\$3,400	\$900	\$2,500
Column sources and formulas	ref. 64	3.2-col. 7 * col. 1	3.2-col. 6 * (19/22)	col. 2 – col. 3	3.2-col. 7 * (1 – col. 1)	3.2-col. 6 * (3/22)	col. 5 – col. 6

*This state has an existing expansion; these findings are estimates of the additional participation and impact that would result under the scenario. Note: States not included in this table have existing Medicaid family planning expansions for women with incomes up to at least the eligibility level anticipated under this scenario; the scenario would result in no new participation in these states.

TABLE A24. Federal and state costs and savings for Scenario 200 Optional, third full year

State	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	2005 federal medical assistance percentage	Federal proportion			State proportion		
		Savings from unintended Medicaid births averted (in 000s)	Spending on expansion services (in 000s)	Net savings (in 000s)	Savings from unintended Medicaid births averted (in 000s)	Spending on expansion services (in 000s)	Net savings (in 000s)
U.S. total	–	\$1,031,900	\$542,300	\$489,600	\$731,000	\$85,600	\$645,300
Arizona	67.45	\$49,400	\$47,400	\$2,000	\$23,800	\$7,500	\$16,400
Connecticut	50.00	\$17,600	\$7,100	\$10,600	\$17,600	\$1,100	\$16,500
Delaware	50.38	\$4,100	\$1,900	\$2,200	\$4,000	\$300	\$3,700
Florida	58.90	\$153,800	\$29,300	\$124,500	\$107,300	\$4,600	\$102,700
Hawaii	58.47	\$5,200	\$2,400	\$2,800	\$3,700	\$400	\$3,300
Illinois	50.00	\$68,600	\$74,300	-\$5,800	\$68,600	\$11,700	\$56,800
Indiana	62.78	\$44,600	\$21,600	\$23,000	\$26,500	\$3,400	\$23,100
Louisiana	71.04	\$90,300	\$31,500	\$58,800	\$36,800	\$5,000	\$31,800
Maine	64.89	\$6,600	\$5,200	\$1,400	\$3,600	\$800	\$2,800
Maryland	50.00	\$37,400	\$21,800	\$15,600	\$37,400	\$3,400	\$34,000
Massachusetts	50.00	\$33,400	\$21,400	\$12,000	\$33,400	\$3,400	\$30,100
Missouri	61.15	\$36,300	\$23,600	\$12,800	\$23,100	\$3,700	\$19,400
Montana	71.90	\$9,700	\$5,000	\$4,800	\$3,800	\$800	\$3,000
New Jersey	50.00	\$37,500	\$24,200	\$13,300	\$37,500	\$3,800	\$33,700
Pennsylvania	53.84	\$36,700	\$39,000	-\$2,300	\$31,500	\$6,200	\$25,300
Rhode Island	55.38	\$7,500	\$2,200	\$5,400	\$6,100	\$300	\$5,700
Texas	60.87	\$348,500	\$134,700	\$213,800	\$224,000	\$21,300	\$202,800
Vermont	60.11	\$3,000	\$1,200	\$1,800	\$2,000	\$200	\$1,800
Virginia	50.00	\$36,800	\$43,100	-\$6,300	\$36,800	\$6,800	\$30,000
Wyoming	57.90	\$4,700	\$5,500	-\$800	\$3,400	\$900	\$2,500
Column sources and formulas	ref. 64	3.3-col. 7 * col. 1	3.3-col. 6 * (19/22)	col. 2 – col. 3	3.3-col. 7 * (1 – col. 1)	3.3-col. 6 * (3/22)	col. 5 – col. 6

TABLE A25. Federal and state costs and savings for Scenario 250, third full year

State	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	2005 federal medical assistance percentage	Federal proportion			State proportion		
		Savings from unintended Medicaid births averted (in 000s)	Spending on expansion services (in 000s)	Net savings (in 000s)	Savings from unintended Medicaid births averted (in 000s)	Spending on expansion services (in 000s)	Net savings (in 000s)
U.S. total	-	\$1,659,000	\$1,082,300	\$576,700	\$1,154,700	\$170,900	\$983,800
Alabama*	70.83	\$2,700	\$8,200	-\$5,500	\$1,100	\$1,300	-\$200
Alaska	57.58	\$9,500	\$4,000	\$5,500	\$7,000	\$600	\$6,400
Arizona	67.45	\$49,400	\$57,300	-\$7,900	\$23,800	\$9,000	\$14,800
Arkansas*	74.75	\$4,800	\$3,400	\$1,400	\$1,600	\$500	\$1,100
California*	50.00	\$32,100	\$33,000	-\$900	\$32,100	\$5,200	\$26,900
Colorado	50.00	\$38,500	\$60,000	-\$21,400	\$38,500	\$9,500	\$29,100
Connecticut	50.00	\$18,500	\$8,600	\$9,900	\$18,500	\$1,400	\$17,200
Delaware	50.38	\$4,800	\$2,500	\$2,400	\$4,700	\$400	\$4,300
District of Columbia	70.00	\$5,600	\$2,000	\$3,700	\$2,400	\$300	\$2,100
Florida	58.90	\$162,600	\$36,500	\$126,100	\$113,500	\$5,800	\$107,700
Georgia	60.44	\$104,500	\$28,800	\$75,700	\$68,400	\$4,500	\$63,900
Hawaii	58.47	\$5,500	\$3,000	\$2,500	\$3,900	\$500	\$3,400
Idaho	70.62	\$13,900	\$5,700	\$8,200	\$5,800	\$900	\$4,900
Illinois	50.00	\$77,500	\$91,100	-\$13,600	\$77,500	\$14,400	\$63,100
Indiana	62.78	\$44,600	\$26,800	\$17,800	\$26,500	\$4,200	\$22,200
Iowa*	63.55	\$4,400	\$2,100	\$2,200	\$2,500	\$300	\$2,200
Kansas	61.01	\$17,800	\$12,900	\$4,900	\$11,400	\$2,000	\$9,300
Kentucky	69.60	\$47,000	\$14,800	\$32,200	\$20,500	\$2,300	\$18,200
Louisiana	71.04	\$100,600	\$37,800	\$62,800	\$41,000	\$6,000	\$35,000
Maine	64.89	\$7,400	\$6,300	\$1,100	\$4,000	\$1,000	\$3,000
Maryland	50.00	\$48,200	\$28,000	\$20,100	\$48,200	\$4,400	\$43,800
Massachusetts	50.00	\$37,500	\$25,900	\$11,600	\$37,500	\$4,100	\$33,400
Michigan*	56.71	\$9,100	\$4,000	\$5,100	\$6,900	\$600	\$6,300
Minnesota*	50.00	\$6,600	\$2,500	\$4,100	\$6,600	\$400	\$6,200
Mississippi*	77.08	\$2,500	\$3,100	-\$700	\$700	\$500	\$200
Missouri	61.15	\$38,500	\$29,600	\$8,900	\$24,500	\$4,700	\$19,800
Montana	71.90	\$9,700	\$6,000	\$3,800	\$3,800	\$900	\$2,900
Nebraska	59.64	\$16,000	\$8,400	\$7,600	\$10,800	\$1,300	\$9,500
Nevada	55.90	\$23,400	\$21,700	\$1,700	\$18,500	\$3,400	\$15,100
New Hampshire	50.00	\$7,200	\$5,600	\$1,600	\$7,200	\$900	\$6,300
New Jersey	50.00	\$42,900	\$30,200	\$12,700	\$42,900	\$4,800	\$38,100
New Mexico*	74.30	\$3,300	\$4,400	-\$1,100	\$1,100	\$700	\$400
New York*	50.00	\$20,300	\$17,900	\$2,400	\$20,300	\$2,800	\$17,400
North Carolina*	63.63	\$8,800	\$19,000	-\$10,200	\$5,000	\$3,000	\$2,000
North Dakota	67.49	\$4,200	\$2,700	\$1,500	\$2,000	\$400	\$1,600
Ohio	59.68	\$67,400	\$88,200	-\$20,800	\$45,600	\$13,900	\$31,600
Oklahoma*	70.18	\$4,600	\$4,900	-\$300	\$1,900	\$800	\$1,200
Oregon*	61.12	\$3,400	\$5,300	-\$1,900	\$2,100	\$800	\$1,300
Pennsylvania	53.84	\$38,700	\$48,100	-\$9,400	\$33,200	\$7,600	\$25,600
Rhode Island	55.38	\$9,100	\$2,600	\$6,500	\$7,300	\$400	\$6,900
South Carolina*	69.89	\$5,400	\$7,600	-\$2,200	\$2,300	\$1,200	\$1,100
South Dakota	66.03	\$4,900	\$2,900	\$2,000	\$2,500	\$500	\$2,100
Tennessee	64.81	\$40,400	\$21,500	\$18,900	\$21,900	\$3,400	\$18,500
Texas	60.87	\$367,000	\$165,200	\$201,800	\$235,900	\$26,100	\$209,800
Utah	72.14	\$14,800	\$7,700	\$7,100	\$5,700	\$1,200	\$4,500
Vermont	60.11	\$3,400	\$1,500	\$1,900	\$2,300	\$200	\$2,000
Virginia	50.00	\$36,800	\$55,200	-\$18,400	\$36,800	\$8,700	\$28,100
Washington*	50.00	\$2,700	\$4,800	-\$2,100	\$2,700	\$800	\$1,900
West Virginia	74.65	\$22,500	\$3,700	\$18,800	\$7,600	\$600	\$7,000
Wisconsin*	58.32	\$3,300	\$2,600	\$700	\$2,400	\$400	\$2,000
Wyoming	57.90	\$4,700	\$6,700	-\$2,000	\$3,400	\$1,100	\$2,300
Column sources and formulas	ref. 64	3.4-col. 7 * col. 1	3.4-col. 6 * (19/22)	col. 2 - col. 3	3.4-col. 7 * (1 - col. 1)	3.4-col. 6 * (3/22)	col. 5 - col. 6

*This state has an existing expansion; these findings are estimates of the additional participation and impact that would result under the scenario.

TABLE A26. Federal and state costs and savings for Scenario Pregnancy Care, third full year

State	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	2005 federal medical assistance percentage	Savings from unintended Medicaid births averted (in 000s)	Federal proportion Spending on expansion services (in 000s)	Net savings (in 000s)	State proportion Savings from unintended Medicaid births averted (in 000s)	Spending on expansion services (in 000s)	Net savings (in 000s)
U.S. total	–	\$1,383,700	\$705,000	\$678,800	\$958,000	\$111,300	\$846,700
Alaska	57.58	\$8,300	\$2,800	\$5,500	\$6,100	\$400	\$5,700
Arizona	67.45	\$44,300	\$33,800	\$10,500	\$21,400	\$5,300	\$16,000
Colorado	50.00	\$33,300	\$47,200	-\$13,900	\$33,300	\$7,500	\$25,900
Connecticut	50.00	\$16,600	\$6,700	\$9,900	\$16,600	\$1,100	\$15,500
Delaware	50.38	\$4,100	\$1,900	\$2,200	\$4,000	\$300	\$3,700
District of Columbia	70.00	\$5,100	\$1,700	\$3,400	\$2,200	\$300	\$1,900
Florida	58.90	\$144,000	\$27,500	\$116,600	\$100,500	\$4,300	\$96,200
Georgia	60.44	\$90,200	\$22,600	\$67,600	\$59,000	\$3,600	\$55,500
Hawaii	58.47	\$4,800	\$2,200	\$2,600	\$3,400	\$300	\$3,000
Idaho	70.62	\$11,900	\$2,800	\$9,100	\$5,000	\$400	\$4,500
Illinois	50.00	\$68,600	\$74,300	-\$5,800	\$68,600	\$11,700	\$56,800
Indiana	62.78	\$39,900	\$16,900	\$22,900	\$23,700	\$2,700	\$21,000
Kansas	61.01	\$15,500	\$7,700	\$7,900	\$9,900	\$1,200	\$8,700
Kentucky	69.60	\$41,900	\$11,400	\$30,500	\$18,300	\$1,800	\$16,500
Louisiana	71.04	\$90,300	\$31,500	\$58,800	\$36,800	\$5,000	\$31,800
Maine	64.89	\$6,600	\$5,200	\$1,400	\$3,600	\$800	\$2,800
Maryland	50.00	\$48,200	\$28,000	\$20,100	\$48,200	\$4,400	\$43,800
Massachusetts	50.00	\$33,400	\$21,400	\$12,000	\$33,400	\$3,400	\$30,100
Minnesota*	50.00	\$9,900	\$3,800	\$6,100	\$9,900	\$600	\$9,300
Missouri	61.15	\$33,800	\$21,900	\$11,900	\$21,500	\$3,500	\$18,000
Montana	71.90	\$8,700	\$3,500	\$5,200	\$3,400	\$500	\$2,800
Nebraska	59.64	\$13,800	\$6,000	\$7,800	\$9,300	\$1,000	\$8,400
Nevada	55.90	\$21,000	\$12,400	\$8,500	\$16,500	\$2,000	\$14,600
New Hampshire	50.00	\$6,200	\$3,900	\$2,300	\$6,200	\$600	\$5,600
New Jersey	50.00	\$37,500	\$24,200	\$13,300	\$37,500	\$3,800	\$33,700
North Dakota	67.49	\$3,700	\$1,500	\$2,200	\$1,800	\$200	\$1,500
Ohio	59.68	\$59,900	\$54,600	\$5,200	\$40,400	\$8,600	\$31,800
Pennsylvania	53.84	\$34,400	\$36,600	-\$2,100	\$29,500	\$5,800	\$23,800
Rhode Island	55.38	\$9,100	\$2,600	\$6,500	\$7,300	\$400	\$6,900
South Dakota	66.03	\$4,400	\$1,800	\$2,700	\$2,300	\$300	\$2,000
Tennessee	64.81	\$35,900	\$16,300	\$19,600	\$19,500	\$2,600	\$16,900
Texas	60.87	\$325,800	\$125,900	\$199,900	\$209,400	\$19,900	\$189,600
Utah	72.14	\$12,700	\$3,700	\$9,000	\$4,900	\$600	\$4,300
Vermont	60.11	\$3,000	\$1,200	\$1,800	\$2,000	\$200	\$1,800
Virginia	50.00	\$32,600	\$33,200	-\$600	\$32,600	\$5,200	\$27,400
West Virginia	74.65	\$20,200	\$2,400	\$17,800	\$6,900	\$400	\$6,500
Wyoming	57.90	\$4,100	\$3,700	\$400	\$3,000	\$600	\$2,400
Column sources and formulas	ref. 64	3.2-col. 7 * col. 1	3.2-col. 6 * (19/22)	col. 2 – col. 3	3.2-col. 7 * (1 – col. 1)	3.2-col. 6 * (3/22)	col. 5 – col. 6

*This state has an existing expansion; these findings are estimates of the additional participation and impact that would result under the scenario.
Note: States not included in this table have existing Medicaid family planning expansions for women with incomes up to at least the eligibility level anticipated under this scenario; the scenario would result in no new participation in these states.

TABLE A27. Hypothetical findings for states with existing expansions, third full year, based on the methodology developed to estimate impact of new expansions

State	(1) No. of expansion participants	(2) No. of unintended pregnancies averted	(3) No. of abortions averted	(4)/(5) No. of unintended births/ Medicaid births averted	(6) Savings from unintended Medicaid births averted (in 000s)	(7) Spending on expansion services (in 000s)	(8) Net savings (in 000s)
U.S. total	2,240,600	323,300	130,300	154,200	\$1,545,900	\$505,600	\$1,040,300
Alabama*	54,100	7,800	3,100	3,700	\$31,000	\$12,100	\$18,900
Arkansas	62,000	9,000	3,600	4,300	\$46,000	\$16,200	\$29,800
California	902,200	130,200	52,500	62,100	\$533,600	\$183,600	\$350,000
Iowa	49,200	7,100	2,900	3,400	\$47,100	\$9,800	\$37,300
Michigan*	125,200	18,100	7,300	8,600	\$112,100	\$13,100	\$99,000
Minnesota	57,000	8,200	3,300	3,900	\$47,800	\$10,600	\$37,200
Mississippi	61,200	8,800	3,600	4,200	\$24,900	\$11,500	\$13,300
New Mexico*	49,100	7,100	2,900	3,400	\$33,000	\$16,300	\$16,700
New York	358,200	51,700	20,800	24,700	\$316,800	\$93,400	\$223,400
North Carolina*	140,200	20,200	8,200	9,700	\$84,500	\$52,200	\$32,300
Oklahoma*	61,900	8,900	3,600	4,300	\$37,500	\$13,400	\$24,100
Oregon	77,800	11,200	4,500	5,400	\$42,200	\$18,900	\$23,300
South Carolina	73,700	10,600	4,300	5,100	\$49,900	\$22,100	\$27,700
Washington	107,800	15,600	6,300	7,400	\$98,000	\$23,800	\$74,300
Wisconsin	61,000	8,800	3,500	4,200	\$41,600	\$8,600	\$33,000
Column sources and formulas	A6-col. 9	0.1443 * col. 1	0.403 * col. 2	0.477 * col. 2	col. 5 * A13-col. 10	col. 1 * A14-col. 6	col. 6 – col. 7

*Existing expansion is limited to individuals aged 19 and older. Table A6, column 9 includes estimates for participants younger than 19. For these states, the formula for column 1 is A6-col. 7 * 83.45%.

Appendix B: Background Tables of Data from External Sources

TABLE B1. Total number of women aged 13–44 and number of women in need of contraceptive services and supplies, by age and poverty status, 2004

State	(1)	(2)	(3)		(4)	(5)		(6)	(7)
	All women aged 13–44	Total	Women in need of contraceptive services and supplies		By age	By poverty status (among those 20–44)			
			<20	20–44		<100%	100–250%	≥250%	
U.S. total	66,260,990	34,413,440	5,004,780	29,408,660	4,670,360	7,721,510	17,016,790		
Alabama	1,016,400	495,940	82,870	413,070	88,090	111,360	213,620		
Alaska	150,400	67,110	10,390	56,730	6,570	14,000	36,150		
Arizona	1,264,100	662,680	89,460	573,210	104,770	165,990	302,450		
Arkansas	602,830	282,770	49,150	233,620	39,520	77,580	116,520		
California	8,292,570	4,428,150	599,730	3,828,430	663,040	1,053,790	2,111,600		
Colorado	1,061,520	546,930	66,730	480,200	59,210	118,480	302,510		
Connecticut	765,450	429,010	62,580	366,440	42,460	69,660	254,330		
Delaware	189,350	97,260	13,750	83,510	10,070	21,110	52,330		
District of Columbia	142,430	82,740	8,450	74,280	14,840	14,150	45,300		
Florida	3,635,530	1,778,690	269,990	1,508,690	219,380	405,770	883,540		
Georgia	2,111,180	1,028,100	159,370	868,730	123,800	239,770	505,160		
Hawaii	263,930	137,070	16,110	120,970	14,580	29,240	77,150		
Idaho	312,580	149,200	21,350	127,850	19,320	46,270	62,260		
Illinois	2,896,560	1,549,040	226,340	1,322,700	197,230	298,410	827,060		
Indiana	1,392,770	731,780	107,580	624,190	102,440	164,900	356,840		
Iowa	642,220	329,540	48,810	280,730	49,310	76,610	154,810		
Kansas	607,010	311,280	47,780	263,500	40,930	77,520	145,050		
Kentucky	931,500	446,880	67,390	379,500	80,480	105,980	193,040		
Louisiana	1,046,450	512,730	91,790	420,940	90,830	115,610	214,510		
Maine	284,040	155,150	23,200	131,950	23,380	35,450	73,120		
Maryland	1,280,920	650,250	95,750	554,500	61,740	110,160	382,600		
Massachusetts	1,474,830	867,850	109,590	758,260	91,040	127,620	539,600		
Michigan	2,265,500	1,197,640	181,330	1,016,300	177,540	251,920	586,840		
Minnesota	1,167,200	610,180	86,300	523,880	56,680	128,870	338,320		
Mississippi	669,860	310,730	59,570	251,160	48,020	82,960	120,180		
Missouri	1,290,730	675,460	100,520	574,940	99,140	165,780	310,020		
Montana	196,350	90,880	12,800	78,080	16,010	26,200	35,870		
Nebraska	387,570	200,150	30,240	169,910	25,160	56,270	88,480		
Nevada	518,680	273,530	33,530	240,000	43,550	66,690	129,760		
New Hampshire	291,820	160,360	24,020	136,340	11,490	28,010	96,840		
New Jersey	1,921,350	1,080,590	151,340	929,240	88,310	158,390	682,530		
New Mexico	423,580	210,800	33,560	177,250	41,300	57,710	78,230		
New York	4,385,860	2,501,520	349,330	2,152,190	348,920	534,410	1,268,860		
North Carolina	1,935,550	934,640	145,150	789,480	130,720	229,770	428,990		
North Dakota	137,850	70,660	10,560	60,100	10,270	20,540	29,290		
Ohio	2,538,980	1,334,570	197,820	1,136,760	175,500	304,720	656,540		
Oklahoma	778,520	373,180	61,060	312,120	47,620	103,870	160,630		
Oregon	788,400	401,310	48,750	352,560	65,580	103,090	183,900		
Pennsylvania	2,665,990	1,501,750	225,520	1,276,230	208,890	306,060	761,280		
Rhode Island	247,040	146,860	19,420	127,440	23,680	29,890	73,880		
South Carolina	949,890	473,930	76,740	397,190	64,670	138,420	194,110		
South Dakota	167,440	83,730	13,320	70,420	16,080	22,460	31,870		
Tennessee	1,335,260	646,140	99,350	546,780	97,840	141,090	307,840		
Texas	5,271,250	2,558,630	383,180	2,175,450	376,100	657,290	1,142,060		
Utah	586,800	314,890	39,010	275,880	34,360	85,900	155,610		
Vermont	135,200	71,140	11,490	59,650	7,540	16,270	35,840		
Virginia	1,703,560	851,890	125,050	726,840	89,030	172,890	464,910		
Washington	1,411,990	728,120	86,710	641,410	98,790	153,520	389,100		
West Virginia	380,700	175,250	28,090	147,160	33,310	42,880	70,970		
Wisconsin	1,234,330	643,420	95,460	547,960	82,820	142,430	322,710		
Wyoming	109,170	51,340	7,390	43,940	8,390	13,780	21,770		

Source: reference 4.

TABLE B2. Total number of women aged 13–44 and number of women in need of contraceptive services and supplies, by age and poverty status, 2002

State	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
	All women aged 13–44	Total	Women in need of contraceptive services and supplies								
			By age				By poverty status (among those 20–44)				
			<18	18–19	20–29	30–44	<100%	100–133%	133–185%	185–250%	≥250%
U.S. total	66,107,760	34,241,690	2,227,640	2,639,610	14,465,900	14,908,540	4,262,550	1,594,940	2,559,540	3,492,460	17,464,960
Alabama	1,025,560	495,870	37,500	44,780	223,030	190,550	72,250	26,800	38,010	55,630	220,890
Alaska	146,310	67,290	4,630	5,460	24,920	32,280	5,770	2,950	5,080	6,500	36,900
Arizona	1,208,890	633,050	37,360	46,490	271,950	277,250	89,800	35,260	58,030	70,130	295,980
Arkansas	599,860	280,300	22,140	26,800	126,580	104,780	40,840	16,650	26,010	34,220	113,640
California	8,274,610	4,387,990	270,940	297,710	1,822,380	1,996,940	616,050	230,970	365,940	424,730	2,181,640
Colorado	1,049,480	546,270	28,020	36,860	227,670	253,720	55,700	22,350	39,380	54,430	309,520
Connecticut	764,260	432,000	28,910	30,530	152,260	220,300	36,080	13,430	23,600	33,420	266,040
Delaware	188,960	95,460	5,550	7,800	41,780	40,340	8,990	3,460	5,880	9,630	54,160
District of Columbia	147,820	85,030	2,760	5,510	44,600	32,160	12,970	3,070	4,390	7,160	49,180
Florida	3,508,840	1,726,160	120,380	133,440	707,350	764,990	207,550	83,670	137,920	203,290	839,910
Georgia	2,073,440	1,008,620	71,020	81,310	441,240	415,050	115,300	44,130	69,820	109,330	517,720
Hawaii	270,720	138,110	6,630	9,210	56,830	65,450	15,510	5,770	11,030	13,870	76,090
Idaho	304,570	145,110	8,750	12,550	66,330	57,480	19,470	8,840	15,380	18,130	61,990
Illinois	2,913,030	1,558,620	105,220	116,430	669,850	667,120	174,060	63,130	102,360	143,890	853,540
Indiana	1,401,420	730,210	45,290	60,190	323,820	300,900	86,500	33,780	55,360	79,560	369,530
Iowa	648,620	327,580	20,460	29,070	151,450	126,610	39,540	16,170	26,900	37,920	157,520
Kansas	612,120	311,250	21,720	26,840	140,030	122,660	38,020	14,920	25,610	33,120	151,020
Kentucky	947,150	445,820	28,610	38,520	201,120	177,560	65,470	23,160	35,670	49,870	204,530
Louisiana	1,056,800	515,960	44,100	49,510	233,120	189,220	88,030	28,740	39,110	54,770	211,690
Maine	288,980	155,380	10,830	12,250	57,740	74,560	18,230	8,090	12,750	17,100	76,120
Maryland	1,288,260	646,970	43,790	47,280	256,720	299,180	48,320	18,240	31,810	56,130	401,390
Massachusetts	1,506,000	882,300	47,240	59,470	347,270	428,330	87,300	27,960	46,480	63,690	550,180
Michigan	2,287,880	1,204,060	80,140	95,770	508,920	519,230	146,850	55,300	85,010	119,070	621,920
Minnesota	1,168,420	607,980	38,090	48,300	258,960	262,640	55,520	23,220	40,480	56,270	346,100
Mississippi	673,500	311,140	27,930	32,100	144,700	106,400	52,240	19,390	25,940	36,330	117,200
Missouri	1,292,040	670,380	44,430	55,350	291,380	279,220	86,870	33,320	54,460	74,610	321,350
Montana	195,950	90,560	5,350	7,740	38,930	38,540	15,590	6,420	9,500	10,670	35,300
Nebraska	389,670	198,160	13,570	17,140	90,820	76,630	23,950	10,160	16,990	23,290	93,060
Nevada	480,360	251,290	13,740	16,470	102,720	118,370	28,920	12,100	21,670	29,300	129,090
New Hampshire	294,260	161,720	10,350	12,660	58,220	80,500	13,030	4,960	9,500	14,880	96,350
New Jersey	1,925,840	1,088,920	73,490	70,610	386,730	558,090	86,880	31,190	53,320	79,010	694,420
New Mexico	420,330	208,030	16,330	17,130	86,520	88,050	35,780	13,730	20,420	22,390	82,250
New York	4,459,710	2,544,420	163,040	177,080	1,012,450	1,191,840	368,310	112,220	172,740	224,560	1,326,470
North Carolina	1,909,860	926,650	60,460	76,510	409,870	379,800	108,420	43,060	70,340	108,840	459,020
North Dakota	140,440	71,280	4,620	6,520	34,530	25,610	10,420	4,380	6,890	8,110	30,330
Ohio	2,571,370	1,350,610	87,480	108,450	576,390	578,280	169,620	62,380	98,410	140,330	683,930
Oklahoma	781,000	373,600	27,350	34,920	170,600	140,730	53,490	21,820	34,330	43,710	157,980
Oregon	778,080	395,490	19,570	28,620	169,870	177,440	55,430	21,040	35,070	45,090	190,680
Pennsylvania	2,700,370	1,514,830	99,390	120,680	595,620	699,140	180,690	63,950	104,000	148,520	797,610
Rhode Island	250,000	146,340	7,470	11,110	60,030	67,730	20,340	6,070	10,040	12,890	78,430
South Carolina	954,280	466,810	33,240	41,210	210,180	182,170	58,140	23,240	37,120	56,410	217,440
South Dakota	167,740	82,080	6,010	7,750	37,470	30,860	12,070	4,910	7,630	9,670	34,050
Tennessee	1,324,670	640,950	42,720	54,290	280,630	263,300	79,770	31,670	49,370	75,350	307,760
Texas	5,155,540	2,507,820	174,540	199,310	1,125,880	1,008,100	340,980	134,950	214,050	283,660	1,160,340
Utah	579,290	306,530	14,500	25,610	164,550	101,870	34,560	14,760	26,290	38,110	152,700
Vermont	139,250	73,080	5,140	6,390	28,810	32,740	8,580	3,530	5,800	8,010	35,630
Virginia	1,709,330	846,100	54,350	65,580	360,940	365,240	80,130	31,910	54,190	85,480	474,470
Washington	1,397,870	718,630	35,240	50,070	293,440	339,880	86,820	32,580	54,300	71,070	388,540
West Virginia	385,640	177,300	11,920	16,440	80,080	68,860	33,050	10,860	14,690	19,280	71,060
Wisconsin	1,239,480	640,420	42,100	53,220	276,110	268,990	67,230	27,260	45,480	65,240	339,910
Wyoming	109,890	51,150	3,220	4,570	22,510	20,850	7,120	3,030	5,000	5,840	22,380

Source: Guttmacher Institute, 2004 (reference 22).

TABLE B3. Distribution of women aged 20–24 by poverty level, 2002–2004

State	(1)	(2)	(3)	(4)	(5)
	Federal poverty level (in %)				Total N
	<100%	100–200%	≥200%	Total	
U.S. total	20.89	22.43	56.68	100.00	10,034,273
Alabama	26.93	22.52	50.55	100.00	150,453
Alaska	13.58	21.88	64.54	100.00	23,752
Arizona	21.94	27.86	50.21	100.00	194,384
Arkansas	31.04	26.96	42.00	100.00	94,819
California	19.88	25.66	54.46	100.00	1,313,470
Colorado	16.27	28.14	55.59	100.00	156,197
Connecticut	16.26	19.07	64.67	100.00	94,065
Delaware	12.69	21.82	65.49	100.00	28,380
District of Columbia	24.87	20.92	54.21	100.00	22,910
Florida	21.11	22.24	56.65	100.00	498,895
Georgia	23.23	25.19	51.58	100.00	301,891
Hawaii	13.98	19.59	66.43	100.00	41,279
Idaho	19.13	33.42	47.45	100.00	50,225
Illinois	21.68	18.54	59.78	100.00	452,389
Indiana	14.92	22.45	62.63	100.00	178,398
Iowa	23.79	24.55	51.66	100.00	95,335
Kansas	19.75	23.95	56.30	100.00	92,086
Kentucky	29.14	22.18	48.68	100.00	145,449
Louisiana	33.08	22.86	44.07	100.00	196,617
Maine	24.56	19.02	56.42	100.00	39,453
Maryland	12.05	21.84	66.11	100.00	167,241
Massachusetts	16.01	13.95	70.04	100.00	188,036
Michigan	22.32	22.14	55.55	100.00	341,973
Minnesota	11.96	23.45	64.59	100.00	171,820
Mississippi	28.92	17.77	53.31	100.00	107,619
Missouri	19.02	23.41	57.57	100.00	177,854
Montana	37.20	25.80	37.01	100.00	30,337
Nebraska	23.80	19.09	57.11	100.00	61,796
Nevada	19.49	26.60	53.91	100.00	70,839
New Hampshire	12.59	15.42	71.99	100.00	43,113
New Jersey	11.84	15.42	72.73	100.00	259,311
New Mexico	31.03	26.99	41.97	100.00	71,292
New York	19.85	15.96	64.19	100.00	669,693
North Carolina	25.36	26.48	48.16	100.00	317,087
North Dakota	22.45	23.42	54.13	100.00	23,368
Ohio	22.92	16.28	60.80	100.00	381,133
Oklahoma	17.22	23.86	58.93	100.00	155,345
Oregon	22.76	25.90	51.34	100.00	102,604
Pennsylvania	20.24	19.29	60.47	100.00	372,682
Rhode Island	15.60	12.33	72.08	100.00	38,188
South Carolina	20.25	24.79	54.95	100.00	147,313
South Dakota	28.33	24.00	47.66	100.00	31,361
Tennessee	23.30	20.76	55.94	100.00	227,630
Texas	24.53	27.26	48.21	100.00	814,329
Utah	13.03	22.18	64.79	100.00	108,584
Vermont	14.86	21.86	63.28	100.00	20,955
Virginia	15.33	18.19	66.47	100.00	266,712
Washington	20.98	23.95	55.07	100.00	214,887
West Virginia	23.37	22.16	54.47	100.00	59,583
Wisconsin	17.54	26.09	56.37	100.00	203,039
Wyoming	22.89	27.95	49.15	100.00	18,099

Notes: Three years of survey data were combined to obtain state-level estimates. This is necessary to increase sample size, reduce sample error and increase the stability of the estimates. Nevertheless, in interpreting differences between states, one must bear in mind that, as survey-based estimates, the data presented are subject to sampling and nonsampling error. For further details, see www.bls.census.gov/cps/ads/1999/ssrcacc.htm. Source: reference 6.

TABLE B4. Distribution of women aged 13–18 by insurance coverage, 2002–2004

State	(1)	(2)	(3)	(4)
	Insurance coverage (in %)			Total N
	Uninsured	Insured	Total	
U.S. total	13.76	86.24	100.00	12,442,480
Alabama	11.08	88.92	100.00	177,051
Alaska	13.10	86.90	100.00	30,924
Arizona	20.08	79.92	100.00	206,524
Arkansas	14.12	85.88	100.00	111,760
California	16.28	83.72	100.00	1,597,195
Colorado	15.18	84.82	100.00	183,059
Connecticut	11.47	88.53	100.00	146,487
Delaware	8.66	91.34	100.00	34,310
District of Columbia	13.33	86.67	100.00	18,357
Florida	20.98	79.02	100.00	691,567
Georgia	13.04	86.96	100.00	338,492
Hawaii	8.79	91.21	100.00	51,136
Idaho	13.20	86.80	100.00	65,809
Illinois	11.99	88.01	100.00	526,504
Indiana	13.03	86.97	100.00	277,807
Iowa	6.50	93.50	100.00	132,303
Kansas	7.33	92.67	100.00	124,066
Kentucky	10.00	90.00	100.00	170,281
Louisiana	16.63	83.37	100.00	178,570
Maine	9.05	90.95	100.00	57,473
Maryland	11.45	88.55	100.00	248,196
Massachusetts	9.91	90.09	100.00	259,921
Michigan	9.47	90.53	100.00	433,086
Minnesota	8.18	91.82	100.00	215,941
Mississippi	12.54	87.46	100.00	139,072
Missouri	6.66	93.34	100.00	248,720
Montana	17.86	82.14	100.00	41,281
Nebraska	6.73	93.27	100.00	74,770
Nevada	17.95	82.05	100.00	96,849
New Hampshire	7.34	92.66	100.00	52,742
New Jersey	12.87	87.13	100.00	368,284
New Mexico	16.40	83.60	100.00	75,106
New York	9.82	90.18	100.00	814,708
North Carolina	15.05	84.95	100.00	354,619
North Dakota	9.35	90.65	100.00	26,397
Ohio	9.02	90.98	100.00	505,182
Oklahoma	23.10	76.90	100.00	144,036
Oregon	15.28	84.72	100.00	137,837
Pennsylvania	9.20	90.80	100.00	500,801
Rhode Island	6.62	93.38	100.00	43,941
South Carolina	9.78	90.22	100.00	187,515
South Dakota	9.50	90.50	100.00	35,569
Tennessee	8.12	91.88	100.00	235,087
Texas	26.84	73.16	100.00	1,017,375
Utah	8.79	91.21	100.00	130,911
Vermont	7.88	92.12	100.00	26,527
Virginia	12.00	88.00	100.00	325,031
Washington	11.50	88.50	100.00	244,186
West Virginia	12.18	87.82	100.00	79,116
Wisconsin	7.54	92.46	100.00	239,703
Wyoming	12.00	88.00	100.00	20,294

Notes: Three years of survey data were combined to obtain state-level estimates. This is necessary to increase sample size, reduce sample error and increase the stability of the estimates. Nevertheless, in interpreting differences between states, one must bear in mind that, as survey-based estimates, the data presented are subject to sampling and nonsampling error. For further details, see <www.bls.census.gov/cps/ads/1999/ssrcacc.htm>. Source: reference 6.

TABLE B5. Distribution of women aged 19–44 by insurance coverage and poverty status, 2002–2004

State	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	<200% FPL			Total N	≥200% FPL			Total N
	Insurance coverage (in %)				Insurance coverage (in %)			
	Uninsured	Insured	Total		Uninsured	Insured	Total	
U.S. total	38.44	61.56	100.00	17,578,387	12.60	87.40	100.00	35,926,199
Alabama	35.10	64.90	100.00	316,014	10.78	89.22	100.00	513,575
Alaska	39.69	60.31	100.00	33,100	15.62	84.38	100.00	82,749
Arizona	38.59	61.41	100.00	380,533	12.60	87.40	100.00	636,052
Arkansas	41.50	58.50	100.00	194,740	15.69	84.31	100.00	288,732
California	41.03	58.97	100.00	2,394,067	15.29	84.71	100.00	4,351,994
Colorado	44.05	55.95	100.00	249,836	11.36	88.64	100.00	617,236
Connecticut	27.29	72.71	100.00	148,513	9.49	90.51	100.00	463,315
Delaware	27.29	72.71	100.00	39,439	9.71	90.29	100.00	114,417
District of Columbia	25.55	74.45	100.00	41,912	9.30	90.70	100.00	84,960
Florida	44.84	55.16	100.00	949,509	16.73	83.27	100.00	1,939,834
Georgia	42.80	57.20	100.00	553,281	13.94	86.06	100.00	1,177,689
Hawaii	22.62	77.38	100.00	60,795	9.00	91.00	100.00	155,504
Idaho	40.04	59.96	100.00	96,179	13.59	86.41	100.00	146,440
Illinois	35.25	64.75	100.00	713,738	11.27	88.73	100.00	1,648,786
Indiana	35.28	64.72	100.00	335,136	11.10	88.90	100.00	789,529
Iowa	33.13	66.87	100.00	158,713	6.48	93.52	100.00	352,478
Kansas	34.64	65.36	100.00	150,224	7.73	92.27	100.00	335,657
Kentucky	36.62	63.38	100.00	288,741	8.38	91.62	100.00	471,657
Louisiana	47.90	52.10	100.00	360,571	15.91	84.09	100.00	498,376
Maine	21.49	78.51	100.00	75,273	8.65	91.35	100.00	151,272
Maryland	41.70	58.30	100.00	231,252	11.25	88.75	100.00	807,419
Massachusetts	25.95	74.05	100.00	292,246	9.19	90.81	100.00	929,289
Michigan	28.85	71.15	100.00	598,248	9.88	90.12	100.00	1,226,362
Minnesota	24.96	75.04	100.00	201,989	6.48	93.52	100.00	736,536
Mississippi	39.02	60.98	100.00	213,315	13.56	86.44	100.00	316,493
Missouri	30.84	69.16	100.00	328,103	10.06	89.94	100.00	698,545
Montana	40.57	59.43	100.00	69,002	15.36	84.64	100.00	85,360
Nebraska	32.20	67.80	100.00	96,594	7.23	92.77	100.00	214,122
Nevada	45.09	54.91	100.00	143,224	14.79	85.21	100.00	268,345
New Hampshire	39.49	60.51	100.00	44,943	10.82	89.18	100.00	190,343
New Jersey	41.66	58.34	100.00	348,437	12.03	87.97	100.00	1,201,991
New Mexico	47.58	52.42	100.00	154,870	19.10	80.90	100.00	182,944
New York	32.81	67.19	100.00	1,196,888	13.46	86.54	100.00	2,410,508
North Carolina	39.97	60.03	100.00	584,605	11.47	88.53	100.00	981,967
North Dakota	23.42	76.58	100.00	36,845	7.08	92.92	100.00	73,819
Ohio	31.12	68.88	100.00	610,620	8.94	91.06	100.00	1,418,214
Oklahoma	42.63	57.37	100.00	239,782	17.71	82.29	100.00	389,256
Oregon	40.69	59.31	100.00	235,548	13.77	86.23	100.00	406,505
Pennsylvania	31.93	68.07	100.00	602,798	10.17	89.83	100.00	1,543,771
Rhode Island	24.50	75.50	100.00	55,012	10.49	89.51	100.00	146,787
South Carolina	33.47	66.53	100.00	274,038	13.45	86.55	100.00	481,794
South Dakota	26.18	73.82	100.00	45,819	9.90	90.10	100.00	85,453
Tennessee	26.30	73.70	100.00	405,031	10.23	89.77	100.00	683,776
Texas	54.96	45.04	100.00	1,705,202	19.53	80.47	100.00	2,492,073
Utah	30.27	69.73	100.00	139,980	11.24	88.76	100.00	316,379
Vermont	20.91	79.09	100.00	32,246	10.72	89.28	100.00	77,549
Virginia	41.46	58.54	100.00	347,710	10.80	89.20	100.00	1,024,685
Washington	34.84	65.16	100.00	372,659	11.66	88.34	100.00	773,211
West Virginia	42.32	57.68	100.00	118,685	13.68	86.32	100.00	184,748
Wisconsin	23.36	76.64	100.00	281,800	8.05	91.95	100.00	701,698
Wyoming	39.31	60.69	100.00	30,583	14.94	85.06	100.00	56,008

Notes: Three years of survey data were combined to obtain state-level estimates. This is necessary to increase sample size, reduce sample error and increase the stability of the estimates. Nevertheless, in interpreting differences between states, one must bear in mind that, as survey-based estimates, the data presented are subject to sampling and nonsampling error. For further details, see <www.bls.census.gov/cps/ads/1999/ssrcacc.htm>. Source: reference 6.

TABLE B6. Percentage of women experiencing contraceptive failure during the first 12 months of method use, after correction for abortion underreporting, by characteristic, according to method

Characteristic	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Implant	Injectable	Pill	Diaphragm/ cervical cap	Condom	Spermicides	Withdrawal	Periodic abstinence
<200% FPL								
<i>Married</i>								
Age <20	2.4	4.2	12.9	ns	23.1	ns	ns	ns
Age 20–24	2.1	3.7	11.4	ns	20.6	ns	37.5	37.5
Age 25–29	1.6	2.9	9.1	22.2	16.6	34.2	30.8	30.8
Age 30+	1.0	1.8	5.7	14.5	10.7	23.0	20.5	20.5
<i>Unmarried, not cohabiting</i>								
Age <20	2.4	4.2	12.9	ns	23.2	45.7	41.6	41.5
Age 20–24	2.3	4.1	12.6	ns	22.7	44.9	40.8	40.7
Age 25–29	2.4	4.3	13.2	ns	23.6	46.4	42.2	ns
Age 30+	1.5	2.6	8.1	ns	14.9	31.1	27.9	27.9
<i>Cohabiting</i>								
Age <20	10.8	18.6	48.4	ns	71.7	ns	ns	ns
Age 20–24	4.7	8.3	24.3	ns	41.1	ns	ns	ns
Age 25–29	ns	ns	13.2	ns	23.7	ns	ns	ns
Age 30+	ns	ns	10.8	ns	19.5	ns	ns	ns
≥200% FPL								
<i>Married</i>								
Age <20	ns	ns	7.6	ns	13.9	ns	ns	32.4
Age 20–24	1.2	2.1	6.7	ns	12.3	26.3	23.5	23.4
Age 25–29	0.9	1.7	5.3	13.4	9.8	21.2	18.9	18.9
Age 30+	0.6	1.0	3.3	8.5	6.2	13.8	12.3	12.2
<i>Unmarried, not cohabiting</i>								
Age <20	1.4	2.4	7.6	ns	14.0	29.4	26.4	26.3
Age 20–24	1.3	2.4	7.4	ns	13.7	28.8	25.8	25.8
Age 25–29	ns	2.5	7.7	19.2	14.3	29.9	26.9	26.8
Age 30+	0.8	1.5	4.7	12.0	8.8	19.1	17.0	17.0
<i>Cohabiting</i>								
Age <20	ns	ns	31.4	ns	51.3	ns	ns	ns
Age 20–24	ns	ns	14.7	ns	26.1	50.3	45.9	ns
Age 25–29	ns	ns	7.8	19.3	14.3	ns	27.0	ns
Age 30+	ns	ns	6.3	15.8	11.7	24.9	ns	22.2

Notes: ns=not shown, because subgroups had fewer than five method-use segments. All estimates are based on a model including duration of use, method, age, union status, poverty status, the interaction between duration of use and method, and the interaction between age and union status. In this model, abortion data in 19 (5%) of 391 cells were transferred to adjoining cells because of lack of exposure. Estimates for "other" reversible methods were included in all the models, but estimates are not shown separately because they do not reflect experience with any specific method.

Source: reference 26.

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