

Protecting Reproductive Health Care for Low-Income Women

An organizing guide for reproductive health care advocates,
low-income health care advocates and
legal service organizations

The Institute for Reproductive Health Access
A Program of the NARAL/NY Foundation
&
The National Health Law Program

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The Institute for Reproductive Health Access

The Institute for Reproductive Health Access of the NARAL/NY Foundation examines issues of access to reproductive health services and develops innovative approaches to expand the availability of abortion and family planning services nationwide. The Institute conducts research projects, develops strategic plans, and trains communities to pro-actively address the most critical issues of family planning and abortion in the United States today. The Institute seeks to assist grassroots reproductive health organizations to confront issues that are national in significance, yet local in approach.

The NARAL/NY Foundation

The NARAL/NY Foundation is dedicated to preserving safe, legal and accessible reproductive health care for all women, regardless of age or economic status. The Foundation is a 501(c) (3) organization, the educational and training arm of the National Abortion and Reproductive Rights Action League of New York State.

The National Health Law Program

The National Health Law Program is a national public interest law firm working to increase and improve access to quality health care on behalf of limited income people by providing legal and policy analysis, advocacy, information and education. Examples of NHeLP's expertise in the areas of Medicaid managed care and reproductive health can be viewed at www.healthlaw.org.

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Foreword

Quality reproductive health care, including family planning, is critical for the health and well being of women of childbearing age and for their families. Yet many low-income women face serious barriers when attempting to access quality and timely care. Restrictions on funding, lack of health coverage, welfare reform, religious restrictions and lack of access to culturally sensitive care, among other obstacles, too often prevent low-income women and adolescents from accessing family planning care.

Unfortunately, since the publicly-financed health system in this country is complicated and difficult to understand, many reproductive rights advocates have become discouraged in their efforts to advocate for low-income women's access to reproductive health care. Legal service organizations, who work closely with low-income communities, would seem to be obvious partners in such efforts. However, as some receive federal funding, there are restrictions placed on the types of advocacy they are allowed. These restrictions are misunderstood and have resulted in many legal service organizations avoiding issues of family planning care.

The Institute for Reproductive Health Access and the National Health Law Program conducted a survey over the last year of health care advocates in order to determine what barriers low-income women face when accessing reproductive health care. We thought this information was important, and we were motivated to inform you about the barriers we uncovered and the strategies we might use to address them. We hope that this information enhances dialogue concerning these issues and inspires more advocates to involve themselves in this work.

The guide is meant as a starting point. It introduces reproductive rights advocates to the public health care system and provides potential roles for reproductive rights advocates to ensure access to family planning for low-income women. It assists legal service advocates in clarifying what advocacy for reproductive health care is allowed under the rules of the Legal Service Corporation. It helps advocates of low-income Americans learn more about the specific barriers to family planning and how advocates may play a role in improving access. It is not a comprehensive guide to all the issues low-income women face; it is intended to be an introduction in order to move us closer towards our united goal of improving the lives of women and their children.

Reproductive health care, low-income health care and legal services advocates must work together to ensure continuous, timely and quality health care, including the full range of reproductive health care services for low-income individuals. We hope that the material provides you with information and background that will enhance your advocacy efforts. We look forward to your involvement.

Sara R. Sills
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How to use this guide

Health care for low-income Americans is in crisis. Over 40 million Americans have no health insurance. Turbulent economic times are leaving more jobless and without adequate health coverage. High costs of health insurance are causing employers to shift costs to employees or discontinue employer-sponsored health care altogether. Simultaneous with the rise in health care costs are rapidly increasing governmental budget deficits at the state and federal levels. States are being forced to find ways to cut costs to balance state budgets, and many are turning to Medicaid. Increasingly, states are imposing enrollment caps on optional populations, dropping expansion plans, shrinking benefits, reducing reimbursement to providers or requiring enrollees to share more in costs. *In this climate, more than ever, advocates must be vigilant about protecting the health care of the poor.*

Reproductive health care is crucial to individuals of child-bearing age. Twenty-four million American women are low-income, with incomes less than 200% of the federal poverty level. One out of every three low-income women is uninsured. One out of every ten non-elderly American women receives health insurance through Medicaid, the nation's health insurance program for poor Americans.¹ Medicaid covers the medical costs of over one-third of all births in the United States.² This substantial and now growing population of poor and disadvantaged women needs access to reproductive health care services, especially as low-income women are at a greater risk of unintended pregnancy, sexually transmitted diseases (STDs), and higher rates of mortality from cervical and breast cancer.

Between May and August 2002, the Institute for Reproductive Health Access and the National Health Law Program conducted a written survey of reproductive health care, low-income health care and legal service organizations nationwide. The survey sought to better

understand the issues advocates are confronting in their state. First, advocates were asked which issues facing low-income individuals they have actively addressed as part of their advocacy activities. Second, advocates were asked to identify current barriers to reproductive health care for low-income women. Lastly, advocates were asked to identify whether they are working in coalition with other organizations, as well as identify any relevant active state coalitions.

We received responses from over one hundred advocates in forty-one states. Based on this information, the Institute for Reproductive Health Access was able to identify key issues surrounding low-income women and reproductive health care. Further, the Institute reached out to a number of responders to find out more information regarding the situation in their states, as well as their involvement in any efforts to ensure continued and expanded access to care. Results from interviews with select reproductive health care advocates are profiled within this guide, to inform advocates who are interested in learning more, as well as offer creative ways to address commonly found barriers. Results from the legal service organization surveys are addressed separately, along with a detailed analysis regarding Legal Service Corporation rules which limit, but do not eliminate, the ability of legal service groups to address reproductive health concerns.

This is not a comprehensive look at all of the obstacles facing low-income women's access to reproductive health care. Rather, these examples are meant to inform advocates who are interested in learning more about obstacles to care and offer creative ways to make improvements. Following each issue is a list of resources to assist advocates in understanding and mobilizing around issues of concern to them and the men and women in their state.

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Removing the Barriers for Public Funding for Abortion

The Hyde Amendment, enacted by Congress 25 years ago, prohibits the use of federal Medicaid funds to pay for abortions, except in cases of rape, incest or when the woman's life is in danger. This discriminatory ban prevents poor women from having equal access to health care and makes it difficult, if not impossible, for many women to exercise their right to choose. Because of the funding ban, women are at heightened risk of being unable to end an unwanted pregnancy. Women who obtain an abortion must divert scarce resources, typically monies used for rent, utilities, food and clothing, to pay for this uncovered medical care. This imposes financial hardship on themselves and family members. The time-consuming challenge of acquiring these funds leads women to have later abortions, resulting in potentially riskier abortion procedures and higher costs.³

Under Medicaid rules, states must, at a minimum, cover abortions in cases of rape, incest or in cases of life endangerment. However, using their own funds, states can choose to provide broader coverage to women. The majority of states cover the bare minimum, often having been ordered by a court to include abortion coverage in cases of rape or incest. Even today, two states (Mississippi and South Dakota) are in violation of federal law because they only cover abortions when a woman's life is endangered. Sixteen states use state funds to pay for medically necessary abortions in broader circumstances.⁴ Only four of these states voluntarily chose to go beyond federal requirements (HI, MD, NY, WA); the other twelve states did so following court decisions (AK, CA, CT, IL, MA, MI, MT, NJ, NM, OR, VT, WV).

The Institute for Reproductive Health Access survey found that inability to access abortion services was a major concern of respondents, with 95 percent of reproductive health advocates noting it as a priority. Of those surveyed who identified lack of access to abortion services as a significant problem, lack of funding for care, difficulty in physically getting to an abortion provider and lack of a provider were often noted as contributing factors.

Despite a federal law requiring Medicaid coverage for abortion in limited circumstances, the process of obtaining reimbursement from the state for performing this service can be cumbersome.⁵ Abortion providers report difficulties in getting approval for coverage; patients and doctors are often unaware of the rules for Medicaid funding; and, states needlessly impose pre-authorization require-

ments that impede timely approval and reimbursement. In Pennsylvania, reproductive health advocates and legal services attorneys identified numerous barriers obstructing patients from getting an abortion in cases of rape, incest and life endangerment. Now advocates are working to remove these obstacles.

“Women shouldn't have to scrape together funds to pay for abortions and abortion funds shouldn't have to dip into scarce resources when Medicaid should be paying.”

– Sue Frietsche
Women's Law Project

PENNSYLVANIA

Removing the Abortion Coverage Obstacle Course

In Pennsylvania, a partnership of three organizations – CHOICE, the Women's Law Project and the Greater Philadelphia Women's Medical Fund – formed to identify the barriers women face when accessing Medicaid abortions and develop ways to overcome them. “For years, women in Pennsylvania have had to run through an obstacle course to get Medicaid coverage for abortions, even in cases of rape or incest,” says Sue Frietsche, Staff Attorney at the Pennsylvania Women's Law Project. This unique alliance of organizations began to examine why Pennsylvania women were being denied coverage for abortions.

With support from the Institute for Reproductive Health Access, the advocates found that providers are often unaware of when Medicaid must cover abortion. Providers were mistakenly telling women that they must pay for the procedure themselves. The groups found that state-developed Medicaid authorization forms were intimidating to physicians, confusing to complete and requiring unnecessary information. Too often, patients had to go from doctor to doctor to get approval for the procedure. Even when all the steps had been taken to secure Medicaid approval for the procedure, abortion providers found that when forms were submitted, it took months before they were reimbursed, if at all.

“The problems are substantial: from July 1, 2000, to April 30, 2001, 243 women sought assistance from CHOICE in obtaining Medicaid abortions in cases of rape or incest,” said Ms. Frietsche. “Many of these women secured Medicaid-funded abortions only after prolonged, strenuous,

white-knuckled advocacy by our three organizations. Many ended up relying on the Fund for loans or grants, as we were unable to clear the obstacles in time for them to have an abortion funded through Medicaid.”

The advocates are now working to remove these barriers. They redrafted the onerous Medicaid approval form and are discussing the adoption of this more streamlined, physician-friendly form with state officials. A brochure has been developed for use by rape-crisis counselors and health care providers to explain a woman’s right to Medicaid coverage and the procedures necessary to obtain approval. Ms. Frietsche concluded, “It is plain and simple: Federal law requires Pennsylvania to pay for abortion care in these terrible situations. Women shouldn’t have to scrape together funds to pay for abortions and abortion funds shouldn’t have to dip into scarce resources when Medicaid should be paying. We are hopeful that in the coming years, with our advocacy continuing, women will get coverage for abortions, doctors will not feel intimidated when they seek approval and providers will get paid.”

In their responses to the Institute for Reproductive Health Access survey, advocates also reported difficulty locating abortion providers willing to accept Medicaid reimbursement. Providers reported that it can be time-consuming to get reimbursed by the state, and often the reimbursement rate is significantly less than the actual cost of the procedure.

KANSAS

The Abortion Fund Safety Net

Kansas is supposed to cover abortions in cases of rape, incest or when a threat to the life of the woman is precipitated by the pregnancy. However, according to Sylvie Rueff, Secretary/Treasurer of the Peggy Bowman Second Chance Fund, the inability of providers to successfully obtain Medicaid coverage from the state makes it difficult to get a Medicaid-funded abortion even in such extreme circumstances. Only 6 sites that provide abortion in the state of Kansas accept Medicaid. Ms. Rueff says, “Providers do not pursue Medicaid because of the bureaucracy, the paperwork, the need for preapproval, the delays, and the low reimbursements.”

Instead, low-income women rely on funds like the Peggy Bowman Second Chance Fund in Lawrence, Kansas to help pay for the abortion. In 2001, the organization received 140 phone calls asking for a total of \$65,000 in help. The Fund was able to provide 85 women with \$12,775 in assistance. This year the numbers have surged. By July 2002, the Peggy Bowman Fund had already received 105 phone calls. Too often they are able to offer no more than \$200 per person, even though the average amount of need is \$500 per person. Nevertheless, Ms. Rueff says “this year, we are getting more financial support than ever. It is unfortunate, though, that the weak economy and regressive political scene is increasing the need for our help.”

WORKING TO INCREASE PUBLIC FUNDING FOR ABORTION

- Where can you get information on your state? The Alan Guttmacher Institute has done some of the most extensive research on the issue of Medicaid funding for abortion. To start, visit their publication *State Policies in Brief: State Funding of Abortion Under Medicaid* and *Issues in Brief: Revisiting Public Funding of Abortion for Poor Women* at <http://www.guttmacher.org>.
- Are there national efforts around this issue? The Campaign for Access and Reproductive Equity (C.A.R.E.2000), a national coalition of over 150 groups pushing for better access to abortion care for low-income women, is running a campaign to pressure Congress to repeal the Hyde Amendment. They also are supporting local educational and advocacy campaigns to highlight the barriers created by the Hyde Amendment. Visit <http://www.care2000.org> to find out more about their essential efforts.
- Who helps low-income women when public funds are not available? The National Network of Abortion Funds (<http://www.nnaf.org>) is an umbrella group for more than 100 organizations that help women in their local communities get and pay for abortion care.
- How do you create a strategy to advocate on this issue? The Institute for Reproductive Health Access works with state-based groups to identify and remove barriers keeping women from getting timely abortion care. Contact them at <http://www.naralny.org> to get help building a campaign to promote better access for low-income women to abortion care.
- Who is leading the legal fight to ensure abortion care? The Center for Reproductive Law and Policy and the ACLU Reproductive Rights Project have been national leaders in litigating to extend Medicaid coverage for abortion in courts across the country. You can contact the Center at <http://www.crlp.org>, and the ACLU at <http://www.aclu.org> to find out about past, current or future litigation or other legal advocacy in your state.
- Where can you get advocacy materials? The National Abortion Federation (<http://www.naf.org>) and the National Abortion and Reproductive Rights Action League (<http://www.naral.org>) have excellent materials addressing abortion and public funding.

Strengthening Title X Funding for Family Planning Services

Title X funding is the only federal funding stream dedicated to family planning services. Without this funding, many providers could not offer women free or low-cost care. In 2001, the federal government provided \$254 million in Title X funding to states.

For background information on Title X funding, see Appendix A.

“The Title X program has helped build a national network of family planning clinics, has established the standards used for the delivery of high-quality but low-cost family planning services nationwide and has enabled millions of women to plan their pregnancies and prevent unintended births.”

- Rachel Gold
The Guttmacher Report, February 2002

NEBRASKA

The Importance of Title X

Nebraska’s Planned Parenthood of Omaha-Council Bluffs (PPOCB) regularly advocates for increased Title X funding because it is their primary source of funding for serving low-income women. According to Beverly Nolte, Vice President of Communications, rates of unintended pregnancy, teen pregnancy and abortion are dropping in Nebraska; at the same time, patient numbers are increasing, particularly due to increased requests for emergency contraception. Ms. Nolte says, “The more access women have to our education and services, the greater ability we have to reduce unwanted pregnancy.” Their patients represent the full childbearing age-range and would be unable to get appropriate care were it not for this funding.

Title X monies are limited and effectively decreasing; according to the Alan Guttmacher Institute, Title X funding has decreased 58% in the last two decades when inflation is taken into account, leaving many clinics without enough funding to cover actual costs.⁶ Clinics often have to make hard choices about the amount and types of services they can offer for free or at a reduced rate. Too often, clinics use up their Title X allocation and have to make service reductions or rely on private funding to fill the gap. Low reimbursement rates leave providers struggling,

and some clinics are being forced to question the benefits versus the burdens of accepting this federal funding. While Title X funding is a vital source of funding for family planning care, it is a constant struggle for providers to meet community needs, while remaining financially viable.

ILLINOIS

The Title X Funding Gap

Title X funding enables Planned Parenthood of East Central Illinois (PPECI) to serve low-income women, but its paltry reimbursement rates force the clinic to operate with a significant financial deficit. An initial patient visit costs the clinic \$152.82. Title X funding reimburses approximately \$58 – a rate of less than 40% of actual costs. As Robin Beach, Director of Client Services explains, “We function with a gap.” The clinic takes several approaches to making up for the Title X shortfall, including applying for foundation grants and soliciting private donations. “Reimbursement rates are just so terrible,” says Ms. Beach. Every April, two months before the end of the fiscal year, PPECI finds that they “have drawn down all [their] Title X money.” However, because sliding-scale services are required to be offered to all eligible clients, they continue to offer reduced rates to patients.

These low reimbursement rates depress the clinic’s revenue. While PPECI serves low-income women, they cannot offer all types of care, and their private funds are being depleted. This prevents PPECI from expanding the services they offer or running certain educational programs. They simply can’t afford to do things that “are not going to be money-makers,” because they must put “all resources into closing that gap.” While some clinics now no longer participate in Title X, Ms. Beach says that they have not yet examined that possibility. “[The program] is there, and it helps a lot of women,” she says. However, Title X seems an empty federal offer “when you’re trying to be fiscally responsible.”

Title X is also a popular target for opponents of family planning. Although Title X is composed of federal funds, the monies are administered at the state and local level. Attacks are occurring locally, making it difficult for clinics to operate or access Title X monies. According to Federal law, Title X funding cannot be used to pay for abortions. However, Title X program guidelines require that providers inform patients who ask for information about their reproductive health care options, information about pregnancy

termination and abortion referrals upon request. Some clinics have established entirely separate budgets for their abortion services to ensure that there is not even a possible appearance of comingling of funds. Nevertheless, clinics are inappropriately accused of using Title X funds to cover abortion care. Some municipalities have recently established laws making it difficult for these clinics to obtain or utilize Title X funds.

MICHIGAN

Anti-Choice Forces Attack Title X Funding

In May 2002, the state of Michigan passed legislation that seeks to deny Planned Parenthood affiliates government money for family planning services. Under new guidelines established in the law, a clinic that performs or refers clients to an abortion provider would be given a lower priority for government funding. Planned Parenthood Centers of West

Michigan does not provide abortion services and is waiting to see how it could be impacted.⁷ Alice St. Clair, Communications Coordinator for the affiliate, says, "It's a real catch-22." In order to follow federal mandates for receiving Title X funds, the clinics must provide women with information about all of their reproductive options, including abortion. However, providing referrals for abortion services would give the clinic a lower priority for funding. The West Michigan affiliate's ten clinics see 23,000 clients annually, four out of five of whom are low-income. It already loses roughly \$50 per client due to limited Title X funding and would be greatly hurt by the loss of government funding.

The new law won't take effect until April 2003, and just how it will be interpreted and implemented remains to be seen. The law, however, is a direct attack on Planned Parenthood health centers and the more than 60,000 Michigan citizens around the state who rely on their subsidized family planning services.

ADVOCATING TO STRENGTHEN TITLE X

- Planned Parenthood Federation of American is a leading force in Washington for maintaining and expanding Title X funding. Find out more in *America's Family Planning Program: Title X*, located at <http://www.plannedparenthood.org/library>.
- The National Family Planning and Reproductive Health Association (<http://www.nfprha.org>) is conducting an aggressive campaign to push the federal government for increased Title X funding.
- Where can you get more information? The Alan Guttmacher Institute has done extensive research and reporting on the Title X program. They have a number of resources that are excellent for advocates looking to learn more about the program including *Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics* and *Issues in Brief: Title X: Three Decades of Accomplishment* at <http://www.guttmacher.org>.
- Who can help in your advocacy? Planned Parenthoods and community health centers across the nation make up a large bulk of the family planning clinics that receive this funding. Contact your local Planned Parenthood at <http://www.plannedparenthood.org>.
- Don't forget to reach out to other community health centers that may provide family planning services. Advocates and providers at these centers provide vital support to your efforts.

Protecting Medicaid: America's Health Safety Net

Medicaid is the primary source of health care coverage for low-income Americans. Medicaid is also the largest funding source for family planning services in the country. Both the federal government and states fund Medicaid, but as Medicaid is largely a state designed and administered program, commitment to Medicaid varies greatly from state to state. While Medicaid only requires states to cover some of the poorest and most vulnerable populations, the federal government has permitted states to expand Medicaid and create separate programs to expand coverage to more uninsured. During the economic prosperity of the 1990s, a number of states expanded their Medicaid programs to cover greater numbers of uninsured.

For background information on Medicaid, see Appendix A.

Now, Medicaid is at risk. Rising health care costs and the economic downturn have placed new burdens on Medicaid programs. Medicaid spending grew 12.8% in 2002, up from 5.4% in 1995. With Medicaid constituting up to approximately 15% of state budgets, states are moving forward to balance their budgets by reducing Medicaid expenditures.⁸ States have already taken different approaches to reduce costs, including requiring greater enrollee cost sharing, limiting access to prescription drugs, reducing reimbursement levels for providers and capping enrollment into programs. A recent Henry J.

Kaiser Family Foundation publication, *Medicaid Spending Growth: Results from a 2002 Survey*, showed that 45 states have taken action to control and/or reduce Medicaid costs.⁹ According to the Institute for Reproductive Health Access national survey of reproductive health care and low-income health care advocates, three quarters of respondents were involved in advocacy around protecting Medicaid and expanding health insurance coverage.

PROTECTING MEDICAID: A STATE PROBLEM WITH A NATIONAL SOLUTION

With states facing increasingly tight budgets, Medicaid is one of the first places state governments turn to cut costs. One way to relieve the pressure on state governments to cut Medicaid is to increase the Federal Medicaid Assistance Percentage (FMAP), which determines how much the federal government matches each state's Medicaid spending. Senators Jay Rockefeller (D-WV) and Susan Collins (R-ME) introduced legislation in the 107th Congress that would temporarily increase federal Medicaid payments by 1.5% through 2004. Advocates can assist this effort by writing to and calling their federal legislators and urging them to support this change. Advocates can also encourage their state legislative leaders to urge federal representatives to support this effort.

ADVOCATING TO PROTECT MEDICAID

- Need the basic information? Go to the Kaiser Family Foundation's *State Health Facts Website* (<http://www.statehealthfacts.kff.org>) for comprehensive information on each state regarding women's health care, Medicaid, SCHIP, the uninsured, and more.
- Ready to start working? If you want to begin advocating to support Medicaid, or to join, or develop a coalition to respond to Medicaid cutbacks, contact Families USA. They have organizing kits that can help you get moving at <http://www.familiesusa.org> – *Preserving Medicaid in Tough Times: An Action Kit for State Advocates* and *The Health Action 2002 Toolkit*. Families USA also provides a list of organizations in each state working on health coverage issues on their website, and sponsors an annual conference giving advocates the opportunity to organize around state policy.
- To get a sense of how legislators might approach Medicaid cutbacks, visit the National Conference of State Legislatures and read *Medicaid Cost Containment: A Legislator's Tool Kit* at <http://www.ncsl.org>.
- Who can help you? Reach out to local legal service organizations to find out more about Medicaid in your state. Find them through the Legal Service Corporation (<http://www.lsc.gov>). Also reach out to community health care centers that might be interested in collaborating to increase access to care.
- To find out more about your state's health programs, Medicaid law or how to advocate around Medicaid, contact the National Health Law Program at <http://www.healthlaw.org>. They work vigilantly to improve access to health care for low-income individuals.

Enrolling the Eligible

While states are unlikely to expand health care programs in the immediate future, advocates can focus their attention on ensuring that all those who are eligible for existing programs are enrolled. Large numbers of the uninsured may be eligible for publicly funded coverage. Eighty percent of the 9 million uninsured children are eligible for either Medicaid or the State Children's Health Insurance Program (SCHIP).¹² Many efforts are underway, by community advocates, health providers, and public agencies, to streamline enrollment procedures and assist potential enrollees to apply for coverage. According to a Kaiser Family Foundation survey, the majority of family planning providers are already involved in efforts to identify eligible individuals, and in some cases, actually aid in the enrollment process.¹³ In our survey of national advocates, over three-fourths of respondents noted that they are engaged in advocacy work around simplifying Medicaid eligibility and enrollment procedures.

MINNEAPOLIS

Reaching the Uninsured

For the past four years, Planned Parenthood Minnesota-South Dakota has been organizing community outreach in Minneapolis to enroll low-income individuals in Medical Assistance, Minnesota's Medicaid program. Catherine Wernecke, Minneapolis Outreach Project Coordinator, reports that advertisements are placed in clinic waiting areas, enrollment forms are available at front desks, and assistance is offered to help patients fill out the forms at their clinics. Clinic staff undergoes training in the Medicaid application process so they can offer sound advice to applicants, and a worker from a local health care advocacy group is on site at one clinic to offer direct help. In addition, Planned Parenthood attends about 30 community events a year to promote the Medicaid program. In the first half of 2002, they spoke with 3,000 individuals about enrolling in the program.

This assistance is key to getting women enrolled. According to Ms. Wernecke, "The application form is quite long and requires a lot of detailed information along with proof to back it up." Applicants in Minneapolis must show recent pay stubs to prove monthly income; documentation of assets is necessary to show they do not exceed the limits. Non-citizens must supply proof of immigration status and date of entry. Thankfully, some efforts to streamline have been effective. The three types of public health insurance once required three different forms; they now require only

one, and a caseworker looks into other programs if an applicant is ineligible for Medicaid.

As in the case of Minneapolis, other advocates are working to simplify the application process, so as not to discourage individuals from enrolling. Some states are focusing on simplifying the actual forms used, limiting the information and number of documents that potential enrollees are required to present in order to prove their eligibility, or easing requirements for annual re-enrollment.

A number of states have begun efforts to remove application-related barriers. According to the Kaiser Family Foundation, 23 states now have forms that can be used for both Medicaid and SCHIP, and 47 states have removed the requirement for an in-person interview when applying for SCHIP.¹⁴ According to the Institute for Reproductive Health Access survey, advocates in 23 states responded that they were advocating to simplify the application process for Medicaid and SCHIP.

NEW YORK

State Simplifies and 380,000 are Enrolled

In response to the September 11th attack on New York City, New York created Disaster Relief Medicaid (DRM) with a simplified enrollment system that enrolled 380,000 New Yorkers in under five months. This remarkably effective emergency public health insurance program met the continuing and expanding needs of New Yorkers during the crisis. The new system applied to all New York City residents, whether or not they were directly affected by the attacks. The system has become a model for simplified enrollment and shows the enormous progress that can be made in enrolling individuals into public programs.

DRM introduced a number of changes including a one-page application, dropping some document requirements, processing applications in one day, increasing eligibility levels and waiving the requirement to re-apply annually. In the period of enrollment between September 19th and January 31st, ten times the normal amount of applications were processed, resulting in one of the highest jumps in enrollment into publicly funded health programs ever. Elisabeth Benjamin, Medicaid expert and Staff Attorney at the Legal Aid Society of New York said, "Because of its simplicity, DRM was wildly successful. City Medicaid offices processed more than 10,000 of the new one-page Disaster Relief

Medicaid applications a week, whereas they used to process only 5,000 regular 10-page Medicaid applications a month.” Advocates have been pushing for a continuation of the simplified enrollment process. Unfortunately, state officials have so far rejected that idea and are returning to the old enrollment forms and procedures.

“Because of its simplicity, Disaster Relief Medicaid was wildly successful. City Medicaid offices processed more than 10,000 of the new one-page DRM Medicaid applications a week, whereas they used to process only 5,000 regular 10-page Medicaid applications a month.”

- Elisabeth Benjamin
Legal Aid Society of New York

THE UNINSURED: A GROWING PROBLEM

Number of Americans without health insurance in 2001: **41.2 million**

Increase in number of uninsured since 2000: **1.4 million**

Percent of American women between the ages of 18 and 64 without health insurance in 1999: **18**

Of Latina women: **37**

Of African-American women: **23**

Of White women: **13**

Percent increase in the average cost of private health insurance premiums between 2001 and 2002: **12.7**

(Sources: 10, 11)

ADVOCATING TO ENROLL THE ELIGIBLE

- How is your state doing? The Kaiser Family Foundation makes it easy to figure out how your state compares in facilitating enrollment of low-income individuals into publicly funded health programs. Check out their report, *Enrolling Children and Families in Health Coverage: The Promise of Doing More – A Report on a National Survey of Enrollment and Renewal Procedures in Medicaid and SCHIP*, Publication #4046 at <http://www.kff.org/content/2002/4046>.
- The Children’s Defense Fund offers resources to help advocates enroll children into SCHIP and Medicaid. The SCHIP Toolkit provides easy to follow information for advocates to use to help your enrollment efforts. Visit <http://www.childrensdefensefund.org>.
- The Northwest Health Law Advocates have a comprehensive *Medicaid Advocacy Guide*, which can help in your work around Medicaid simplification at <http://www.nohla.org>.
- For materials specific to simplifying Medicaid, look at the Kaiser Family Foundation Report *Reaching Uninsured Children through Medicaid: If You Build It Right, They Will Come*. The report, publication #4040, is available at <http://www.kff.org/content/2002/20020611>.
- The Urban Institute has also published an article specific to this topic. Available at <http://www.urbaninstitute.org>, view *Why Aren’t More Uninsured Children Enrolled in Medicaid or SCHIP?*

Expanding Family Planning Care: Using the Medicaid Waiver Process

Medicaid only provides health care to the poorest in our society, leaving many low-income individuals uninsured. Covering only 34 percent of low-income women, many low-income women are left without coverage for family planning services.¹⁵ Uninsured women are forced to pay these necessary health costs out-of-pocket, or must turn to subsidized care to help pay for family planning services. Some women forego or delay care because family planning services are unaffordable. Recognizing the significance of providing family planning coverage, some states sought to obtain waivers from the federal government under Medicaid to give more women access to these services. Seventeen states have implemented §1115 demonstration waivers (see box), specifically targeted to provide reproductive health services to low-income women not eligible for Medicaid.

These waivers allow states to cover more women, while offering financial benefits for the state. Since family planning services are reimbursed by the federal government at a 90% matching rate, the state is only covering 10% of the costs. As better access to family planning services will decrease the rate of unplanned pregnancies among women and adolescents, states are saving funds that would otherwise have to be spent on prenatal care and delivery. It is estimated that for every dollar the government spends on family planning care, it saves three dollars on pregnancy-related care.¹⁶

HOW DO SECTION §1115 WAIVERS HELP PROVIDE FAMILY PLANNING SERVICES UNDER MEDICAID?

§1115 Waivers allow states to “waive” certain laws pertaining to Medicaid in order to conduct a research and/or demonstration project. In terms of family planning, these waivers allow the states to:

1. Extend postpartum coverage for family planning services for up to five years.
2. Expand eligibility for family planning beyond the state’s Medicaid income eligibility levels for other services.
3. Provide family planning to once enrolled Medicaid recipients who no longer meet eligibility criteria.

One of the first states to implement a family planning waiver, Rhode Island documented significant benefits in the health status of women and showed striking financial benefits for the state. During the first four years of the waiver, which expanded postpartum family planning care for two years, the percentage of Medicaid-covered women who had become pregnant within nine months of a previous pregnancy decreased from 20 to 11 percent. Further, the state estimated that the waiver helped prevent almost 1,500 unplanned pregnancies among the Medicaid population, saving the state \$14.3 million.¹⁷

STATES WITH ACTIVE AND PENDING FAMILY PLANNING WAIVERS (AS OF OCTOBER 2002)

	Extending Postpartum Coverage	Higher Income Eligibility Levels	Coverage After Loss of Medicaid
Approved	Arizona Florida Maryland Missouri New York Rhode Island Virginia	Alabama Arkansas California New Mexico New York Oregon South Carolina Washington Wisconsin	Delaware
Pending	Illinois	Colorado Minnesota Mississippi North Carolina Oklahoma	

The experience in Rhode Island demonstrates that these waivers have positive benefits for women, and save money. Oklahoma’s experience demonstrates the long and arduous process of getting a waiver approved. Waiver applications in some states must be approved by state legislatures, involving a drawn out discussion, sometimes a pitched battle at the state level, before advocates even begin having to advocate with the federal government for approval. At that point, political affiliations can create obstacles where state leaders are of different political parties than the federal administration.¹⁸

While of immense value, it may take tremendous resources – time, money, and organizational energy – to get a family planning waiver approved.

OKLAHOMA

Working to Expand Family Planning for Low-Income Women

Planned Parenthood of Arkansas and Eastern Oklahoma is well aware of the benefits that a family planning waiver would provide. The eighth poorest state, Oklahoma's current Medicaid program covers family planning services for women with incomes of up to 40% of the federal poverty level (\$6,008 for a family of three in 2002). Advocates in Oklahoma, led by Planned Parenthood, developed a waiver that would give women with incomes up to 185% of the federal poverty level publicly funded reproductive health care coverage. They estimate that the waiver could provide coverage to over 120,000 women and prevent over 8,000 unintended pregnancies each year. Following seven years of lobbying and advocacy, the waiver is ready to be submitted to the federal government for final approval. These efforts were supported by a statewide coalition of over 50 member organizations, including reproductive rights, health care and progressive issue advocates. Nancy Kachel, President and

CEO of Planned Parenthood of Arkansas and Eastern Oklahoma, and a driving force behind the waiver, said, "The only thing that has kept the waiver moving during this time is the incredible support we have had from our many coalition partners around the State that have kept the pressure on state officials."

FAMILY PLANNING EXPANSION: HOW THE FEDS COULD HELP

One solution that has been proposed by advocates, and in Congress, is to allow states to expand family planning coverage without having to apply for a waiver. The federal government now allows states to expand coverage for pregnant women above Medicaid levels without a waiver. Under the Family Planning State Empowerment Act of the 107th Congress (S.1343, HR.2777), the federal government would allow states to expand eligibility for family planning services without obtaining a waiver, permitting states to more quickly implement these money-saving and health-promoting policies, if supported at a state level.

ADVOCATING FOR FAMILY PLANNING WAIVERS

- Which states have family planning waivers? The Alan Guttmacher Institute (<http://www.guttmacher.org>) has published extensive information regarding the need for these waivers, as well as their affects on health care. AGI also regularly updates their *State Policies in Brief*, which provide the most updated information regarding the status of family planning waivers across the country.
- Where can you get more information? Get up-to-date information on the status of family planning waivers across the nation at the Kaiser Family Foundation State Health Facts website (<http://www.statehealthfacts.kff.org>) Their report, *Medicaid Coverage of Family Planning*

Services: Results of a National Survey, provides a detailed analysis of the family planning waiver at <http://www.kff.org/content/2001/2216>.

- Who can help? The Institute for Reproductive Health Access has provided direct support to states pursuing a waiver. Contact them at irha@naralny.org or <http://www.naralny.org>.
- Planned Parenthood Federation of America works with its affiliates to help them understand the waiver process and can provide help in getting one approved. Contact PPFA at <http://www.plannedparenthood.org> to find out how they can help.

Expanding Coverage and Shrinking Care: The New HIFA Waivers

In August 2001, the Bush administration announced a new Medicaid and SCHIP waiver initiative (see box) called the Health Insurance Flexibility and Accountability (HIFA) Initiative, to help states gain faster approval of projects that seek to expand health insurance coverage to previously uncovered populations, while maintaining “budget neutrality”. These new initiatives have advocates greatly concerned. While the new waivers give states opportunities to expand health care coverage, the states must show the federal government that the coverage expansion will not require additional federal financial resources. This is achieved by giving states the ability to reduce benefits, cap enrollment for optional Medicaid populations and impose higher costs on consumers, with no limits on out-of-pocket costs (see Appendix A for Medicaid background information).

§1115 AUTHORITY

§1115 of the Social Security Act grants the Secretary of Health and Human Services broad authority to waive certain federal laws relating to Medicaid for the purposes of conducting research or demonstration projects. §1115 waivers allow states to alter their Medicaid programs to differ from federal standards in terms of eligibility, the freedom to choose a provider, the scope of services available, and reimbursement. Demonstration waivers have been used to implement Medicaid managed care programs and expand health care to new populations. The HIFA initiative is also based on the §1115 authority.

Individuals that are guaranteed coverage by federal law (so-called “mandatory” populations), are not affected by

this initiative. HIFA waivers, however, can affect services for those populations that the state has opted to cover. In essence, these so-called “optional” populations run the risk of a rollback in benefits. According to Mara Youdelman, Staff Attorney at the National Health Law Program, “Although HIFA is being marketed as a vehicle for health coverage ‘expansion’, its requirement that states spend no more than they would have without the ‘expansion’ means that for many of the very poorest Medicaid beneficiaries, HIFA waivers are nothing more than a benefit cut in disguise.”

States have the option of creating health programs that exclude family planning services, whereas in the past, these services were always guaranteed under a Medicaid waiver. Further, the HIFA program promises to expedite the Federal government’s approval process of a waiver to allow states to make adjustments to their program in a timely manner. This shortens the amount of time available to advocates to review and comment on the program content and design.

The National Health Law Program is tracking the development by states of these new waivers. To find out about these waivers, visit the National Health Law Program’s *WaiverWatch* at <http://www.healthlaw.org/waiver.shtml>. You can view state-by-state information regarding waiver developments, as well as advocates’ comments.

As of October 2002, six states have active HIFA waivers (Arizona, California, New Mexico, Maine, Utah, Oregon), and five states have pending applications (Colorado, Delaware, Michigan, Oregon, Washington).¹⁹

ADVOCATING ON THE NEW HIFA WAIVERS

- Need more information on what HIFA is? The Kaiser Family Foundation has a comprehensive explanation in *The New Medicaid and SCHIP Waiver Initiatives* at <http://www.kff.org/content/2002/4028>.
- What could these waivers mean for low-income Americans? Families USA’s *HIFA Waivers: What’s at Stake for Families* is a good introduction to the dangers of the HIFA waiver. Also view the *Preserving*

Medicaid in Tough Times: An Action Kit for State Advocate at <http://www.familiesusa.org>.

- How can HIFA waivers affect family planning? The October 2002 Guttmacher Report features *New Medicaid Initiative, State Budget Woes Collide*, an article detailing the history and status of HIFA waivers, as well as their implications for family planning at <http://www.guttmacher.org>.

Family Planning and Medicaid Managed Care

Over half (56%) of all Medicaid recipients are now enrolled in managed care plans. As of 2002, only two states, Arkansas and Wyoming, had not implemented some type of managed care program for Medicaid beneficiaries.²⁰ The implementation of managed care within Medicaid was originally envisioned as a way to contain health care costs while providing patients with more coordinated care. Through the coordination of care, which is a notable feature of managed care, providers can ensure that women are getting appropriate levels of care from different providers who share patient diagnosis and treatment information.

However, managed care can also hinder access. Managing the care of a population that often lacks formal education, and that may have literacy or language barriers, is an obvious difficulty. The use of primary care providers as “gatekeepers” and the reliance on approvals for referrals and preauthorization of treatment may interfere with access to care. The emphasis on care coordination may also conflict with the confidentiality concerns of women, particularly teenagers. Finally, Medicaid managed care may not address the lack of providers in poor or rural neighborhoods and could weaken the network of family planning providers who have traditionally provided care to poor women.

Medicaid Managed Care: Access to Traditional Providers Through Free Access

Low-income women often prefer to use community-based family planning clinics to receive reproductive health services.²¹ Early in the Medicaid managed care experiment, women enrolled in Medicaid managed care discovered they were to receive care from providers contracting with their Medicaid HMO, rather than traditional family planning providers who had met their family planning needs for years. To ensure continuity in the delivery of family planning services, federal law was changed in 1986 permitting women to go to any family planning provider who accepts Medicaid, regardless of whether or not that provider is covered under their managed care plan.²² While a few states have waived this requirement, the majority of states have implemented the “Free Access” policy (sometimes known as “freedom of choice”).²³ Some combination of the state, plan and/or a broker must inform beneficiaries regarding how they can access care, what services are covered, and where they can go.

Each state determines who holds the responsibility for this notification, the state or the HMO.²⁴ According to a national survey by the Henry J. Kaiser Family Foundation

THE BALANCED BUDGET ACT AND MEDICAID MANAGED CARE

Throughout the 1990s, many states began looking to implement managed care within their Medicaid program as a way to ensure continued care while containing costs. In 1997, the Balanced Budget Act gave states the expanded ability to adopt programs to mandatorily enroll Medicaid enrollees into managed care. Prior to this, the states had to apply for special permission to do so. In return for allowing states to implement managed care programs without a federal waiver, the Balanced Budget Act requires states to adhere to a set of requirements. The Bush Administration released the final set of these regulations in June 2002.

In the August 2002 issue of *The Guttmacher Report (States Key to Women's Family Planning Access Under New Medicaid Managed Care Rules)*, Rachel Gold explains how the regulations affect reproductive health care. First, the regulations state that plans and states are only responsible for providing complete information on covered services at the time of enrollment. Each year afterwards, enrollees need only be informed about their right to request this information. Second, in cases of managed care plans that refuse to provide or refer for services due to a moral or religious objection, while the state is held responsible for informing enrollees, the regulations make no efforts to establish a set system to ensure women can find out how to access these services. Third, the regulations allow an individual to obtain health care services from a gynecologist without getting permission from one's own primary care provider (known as “direct access”). However, the regulations do not define family planning as a set of services for which women can have direct access. This focus on the provider, and not the services, could be interpreted to leave room for states to deny direct access to family planning providers. The regulations are written broadly. It will be left to state advocates to work in each state to ensure that women can get the information they need and the services necessary to maintain their health.

and earlier research by the Institute for Reproductive Health Access, enrollees are not always informed regarding their rights to access services from out-of-network providers. The Kaiser survey reported a serious lack of effort to inform enrollees, confusion among providers and plans, as well as the difficulty of delivering abundant and complete information to enrollees.²⁵ This can leave the Medicaid population without timely access to reproductive health care, even though for many of these services, timely access is crucial.

Medicaid Managed Care: Religiously-Affiliated HMOs

According to federal law, under the Balanced Budget Act of 1997, religiously affiliated managed care plans are allowed to refuse to provide or refer for any services for which the plan has an ethical or moral objection, including reproductive health care services. Under federal guidelines, the state must inform enrollees about which services are not covered, and how they can access them elsewhere.²⁶ Many states rely on the “Free Access” system to ensure continued access to care, by requiring plans and providers to allow women to obtain care from family planning providers.

Fifteen religiously affiliated HMOs in the United States serve the Medicaid population. All but two of these religiously affiliated plans have arranged family planning care through either a third-party billing system or a partnership with a non-religious insurer.²⁷ Two plans, the New York State Catholic Health Plan (known as Fidelis) in New York and AmeriHealth Mercy in South Carolina carve-out this care and require women to go out-of-network to obtain family planning services. These plans refuse not only to provide these services, but also to refer for them. Female enrollees are often misinformed and are unsure of how to access this care, often delaying or preventing them from timely family planning services.²⁸

“Fidelis’ carve-out policy for family planning care is potentially harmful to women.

Fidelis’ policy contradicts the basic principle of managed care, which is to provide coordinated care.”

- Kirsten Aspengren
Care for the Homeless

NEW YORK

Catholic HMO Carves-Out Care and Advocates Respond

In New York State, Fidelis is the largest Medicaid managed care plan in the state, serving over 100,000 women. Under the control of the Catholic Church, Fidelis chooses to “carve out” family planning services, based on a religious objection. This leaves women and adolescents covered by Fidelis without in-network access to services such as birth control, abortion and sterilization. Therefore, Fidelis enrollees are often forced to seek this essential care from out-of-network providers. NARAL/New York undertook a series of focus groups with women covered by Fidelis and found numerous instances where Fidelis’ “carve out” policy delayed enrollees from getting care in a timely manner. Marketing and membership materials included misleading and confusing information and Fidelis failed to advertise to its potential and current enrollees which services are not covered, or how to obtain these services elsewhere.²⁹ Kirsten Aspengren, Managed Care Education Coordinator at Care for the Homeless in New York City, explained, “Fidelis’ carve-out policy for family planning care is potentially harmful to women. Fidelis’ policy contradicts the basic principle of managed care, which is to provide coordinated care. When plans, such as Fidelis, move family planning care out of network, they interrupt continuity of care thus defeating the purpose of managed care.”

Under New York’s sweeping Medicaid managed care program, women who do not choose a managed care plan are automatically enrolled into a Medicaid HMO. Today, thousands of women are being automatically enrolled in Fidelis, a plan that does not provide the full range of services that most women of childbearing years require. NARAL/NY released the first in-depth study of Fidelis in 2000 that prompted NY State Comptroller Carl H. McCall to release a scathing evaluation of Fidelis. Advocates have reached out to human services providers who work with low-income women across the state to increase awareness about Fidelis and help them educate their clients about Fidelis’ carve-out policy. NARAL/NY and a host of organizations are now working with officials in the New York City Council to develop legislation that will address the failure of Fidelis to prominently inform Medicaid enrollees of their lack of family planning coverage and to offer better protection to women who are faced with automatic enrollment into Fidelis.

ADVOCATING ON FAMILY PLANNING AND MEDICAID MANAGED CARE

- What are your state's policies? Turn to the Kaiser Family Foundation. Their report, *Medicaid Coverage of Family Planning Services: Results of a National Survey*, is indispensable in your research. Visit <http://www.kff.org/content/2001/2216>.
- The Institute for Reproductive Health Access' *Reshaping Reproductive Health: A State-by-State Examination of Family Planning Under Medicaid Managed Care* can also provide you with a snapshot of how states are addressing Medicaid managed care. Visit <http://medicaidmanagedcare.naralny.org>.
- Need more information? The Alan Guttmacher Institute is an authority on Medicaid and family planning. You'll want to read both *Medicaid Support for Family Planning in the Managed Care Era* and *Issues in Brief: Reproductive Health Services and Managed Care Plans: Improving the Fit* at <http://www.guttmacher.org>.
- What about Catholic-run HMOs? To find out about the New York experience with a Catholic-run HMO, take a look at the NARAL/New York Foundation report, *When Religion Compromises Women's Health Care: A Case Study of a Catholic Managed Care Organization*. Order at naralny@naralny.org or visit <http://www.naralny.org>.
- Catholics for a Free Choice keeps a watchful eye on Catholic hospitals and HMO developments. Their 2000 report, *Catholic HMOs and Reproductive Health Care* provides an important national picture on Catholic HMOs, and is available at <http://www.catholicsforchoice.org/pubs/hmoexecutivesummary.pdf>.
- MergerWatch, a project of Family Planning Advocates of New York State, can provide help if you encounter problems with Catholic-run HMOs or health care networks (<http://www.mergerwatch.org>).
- Have more questions about the Balanced Budget Act? The National Health Law Program (NHLP) is a legal expert on issues of Medicaid managed care. Their website, <http://www.healthlaw.org>, offers vast resources that can help you understand federal law and regulations, like the Balanced Budget Act. Their staff are ready to assist you in answering specific questions about Medicaid managed care in your state and to help with advocacy efforts.
- What does a Medicaid managed care contract look like? The Center for Health Policy Research at George Washington University undertakes extensive research looking at each state's Medicaid managed care contracts and the way it addresses specific health services, including family planning care. You can look at your state's "model" Medicaid managed care contract and compare it to other states at <http://www.gwu.edu>.

Low-Income Adolescents and Reproductive Health Care

The State Children's Health Insurance Program (SCHIP) of 1997 created a means for almost all low-income children and adolescents to get health coverage. As of March 2002, approximately 3.8 million children were covered under SCHIP. Even still, one out of five children lack health coverage though they may be eligible for publicly funded programs. Equally disturbing is the high uninsured rate among all teenagers. According to the American Academy of Pediatrics October 2002 report, *Children's Health Insurance Status: Medicaid/SCHIP Eligibility and Enrollment*, 16% of teenagers aged 13-18 were uninsured for a full year.

For background information on the State Children's Health Insurance Program, see Appendix A.

States were given wide flexibility by Congress to structure their SCHIP programs and have taken varying approaches in setting eligibility levels, establishing the design of the program, and promoting enrollment into the program. According to Rachel Gold and Adam Sonfield of the Alan Guttmacher Institute, "The degree to which CHIP can help adolescents meet these reproductive health needs depends largely on the decisions that individual states make in designing their efforts."³⁰ States have the option to use SCHIP federal funds either to expand Medicaid, create a separate SCHIP program, or to do a combination of both. Those states that expanded Medicaid generally kept the Medicaid benefit package, thereby providing coverage for family planning. The states that chose to create their own SCHIP programs had greater flexibility to design benefit packages and had the option to exclude family planning.

While states receive federal funding to cover children, SCHIP is not invulnerable to coming under the budget axe of state officials. States receive a set amount of federal funding and since the program does not guarantee coverage or create an entitlement, states have taken steps to freeze enrollment, and to reduce outreach and marketing to slow enrollment and cut benefits. In 2002, Montana, North Carolina and Utah froze enrollment to hold down spending. Utah dropped dental coverage under SCHIP.³¹ As budgets are being carefully scrutinized and often cut, advocates need to be watchful that family planning services are not eliminated or made more difficult to access under their SCHIP program. This may be particularly so in conservative states that are already reluctant to spend on family planning care for adolescents.

Adolescents may also face other difficulties accessing family planning care under SCHIP. Teens are often fearful of a loss of confidentiality if they use their SCHIP coverage. A Kaiser study noted that confidentiality policies of managed care plans in SCHIP might deter adolescents from seeking family planning services from network providers.³² Ensuring that adolescents, particularly minors, can receive confidential reproductive health care depends on more than the existence of laws that establish their right to give their own consent for care. Unless the care, especially through insurance programs like Medicaid and SCHIP, is coordinated with the state's consent and confidentiality laws, young people's right to confidential care may be one that is legally protected, but ignored. When bills or benefit statements are sent home, with the potential for a parent discovering that his or her teenage child received family planning care, the right to confidential care may be a hollow one.

Further, adolescents may also not know that their SCHIP coverage affords them access to family planning care and states may not have targeted activities to enroll adolescents into SCHIP programs. A study by the Alan Guttmacher Institute found that 40 out of 48 SCHIP programs are not adequately informing adolescents about their ability to access family planning services, as well as what services are covered. Only half of states (27 of the 46 states surveyed) reported having targeted outreach activity to adolescents.³³

PROTECTING SCHIP FROM CUTS: A NATIONAL ANSWER

When originally adopted, the State Children's Health Insurance Program was developed so that funding levels would remain the same through 2002, then decrease in the years following. However, with the falling economy, advocates are pressing to maintain current levels of funding. Senate legislation S.2860 in the 107th Congress would retain past funding levels through 2004. Advocates should support this and similar congressional efforts.

MAKING SCHIP WORK FOR ADOLESCENTS

- Want more information about family planning and SCHIP? Check out this study by the Alan Guttmacher Institute: *Reproductive Health Services for Adolescents Under the State Children's Health Insurance Program* in the March/April 2001 issue of The Guttmacher report at <http://www.guttmacher.org>.
- Does your state's SCHIP program include family planning? Find out by looking at your state's SCHIP program at the Center for Medicaid and Medicare Services website, <http://www.cms.hhs.gov/SCHIP>, or contact your state health department.
- What is the design of your state's SCHIP program? Visit the website <http://www.insurekidsnow.gov> to find out more information about enrollment and eligibility in different states.
- Where can you go for advocacy materials? The Children's Defense Fund's are leaders in the advocacy efforts around SCHIP; they have an excellent advocacy toolkit at <http://www.childrensdefense.org/pdf/healthtoolkit.pdf>.
- The Robert Wood Johnson Foundation also has a national health access initiative focused on increasing children's access to health care. Visit <http://www.coveringkids.org>.
- Who should you reach out to in your community? There are no better advocates for the SCHIP program than physicians. The American Academy of Pediatrics (<http://www.aap.org>) supports including family planning care in the SCHIP program. At their website you can obtain a copy of their recommendations, *Improving the Implementation of State Children's Health Insurance Program for Adolescents* which lays out authoritative recommendations for structuring a SCHIP program in your state.
- Where can you go for help? The Center for Adolescent Health and Law provides legal and policy expertise on issues affecting adolescents and their ability to obtain essential health services. The Center can provide excellent assistance in your advocacy efforts and can be contacted at <http://www.adolescenthealthlaw.org>.

Ensuring Immigrant Access to Family Planning

Over 30 million foreign-born individuals live in the U.S., comprising 11 percent of the total population.³⁴ Approximately 7.5 million of these foreign-born residents are uninsured.³⁵ Not surprisingly, immigrants are disproportionately employed in jobs at the lower rungs of the economic ladder and often go without health insurance. Only one out of four (26%) of immigrants have job-based health coverage.³⁶

Because of their poverty and lack of employer-based health coverage, Medicaid is a significant source of coverage for immigrants, although it is increasingly difficult to obtain. Immigrants' access to health care services became harder with the passage of the 1996 "Welfare Reform" law which severely restricted eligibility to Medicaid for many immigrants, including those who had previously been eligible.³⁷ These restrictions also apply to the State Children's Health Insurance Program (SCHIP). Eligibility for public health programs rests on a number of factors such as a person's legal status under immigration laws, date of entry into the country and the amount of time spent in the U.S. Some states have adopted programs, using only state funds, to cover immigrants who do not qualify for federally financed coverage.

Besides the lack of coverage, immigrant women often face other barriers when accessing care. Some immigrants, due to negative experiences in their native countries, may hold a wary view of family planning. Other

HEALTH CARE FOR IMMIGRANTS: HOW THE FEDS CAN HELP

Bipartisan support is building to improve health coverage for immigrants. Health advocates, immigrant groups, faith-based organizations, the National Governor's Association and others are pushing national lawmakers to allow states the option of enrolling legal immigrant pregnant women and children in Medicaid and SCHIP. Permitting states to draw down federal monies for Medicaid and SCHIP coverage for legal immigrant pregnant women and children would prompt states to expand coverage to these vulnerable populations. Senator Bob Graham of Florida has been pushing for these changes for years. Advocates may consider joining these efforts and pushing their federal representatives to support this step.

IMMIGRANTS: BARRIERS TO CARE

Number of immigrants living in the US today:
30 million

Ratio of immigrants to total US population:
1 to 10

Percent of immigrants who get
insurance coverage from employers:
26

Percent of low-income non-citizen women who are uninsured:
56

women may have misplaced, but deeply held fears that seeking care will jeopardize their residency status in the U.S. and lead to deportation for them and their families. Language barriers may obstruct a woman's ability to inform herself about access to publicly funded care and family planning services.

CONNECTICUT

Fear Can Keep Immigrants Away: One Clinic's Experience

The Fairhaven Health Center in New Haven, Connecticut, is a federally qualified community health center that for more than thirty years has served low-income patients in a largely Latino community. Director of Patient Services Lynn Price said, "The word is still getting out that we're a safe place to come." With an increasing number of patients coming as refugees from Central and South America, Ms. Price noted, "In the places where these folks are coming from, government may be seen as a bad thing. And clinics at home belong to the government. So, patients may translate that to, if you come to a clinic in the United States, the government will know about you."

In states with high numbers of immigrants, respondents to the Institute for Reproductive Health Access survey noted that family planning providers experience considerable financial difficulty in meeting the demand for services from uninsured immigrant women. Rising numbers of immigrant women seeking family planning care placed additional financial pressures on providers already financially strapped by declining Medicaid participation and revenue and larger numbers of uninsured patients.

REMOVING BARRIERS FOR IMMIGRANTS

- Where can I get more information? The Kaiser Family Foundation has a number of publications addressing immigrant health coverage. Visit *Immigrant's Health Care: Coverage and Access* at <http://www.kff.org/conent/2000/2003>. View *How Have State's Responded to the Eligibility Restrictions on Legal Immigrants in Medicaid and SCHIP?* at <http://www.kff.org/content/2002/20020628>.
- Who can help? The National Immigration Law Center (<http://www.nilc.org>) is a national leader in advocating for immigrant's access to health services. Contact them for information about immigrants' access to health care in your state and to keep informed about national developments.
- The National Health Law Program is a also key advocate for issues regarding immigration. Visit their *Revised Resource Manual on Immigrant Access to Health Benefits Released by The Access Project and the National Health Law Program*, for some of the most comprehensive information available regarding immigrant's access to health care at <http://www.healthlaw.org/immigrant.shtml>.
- Who else can help you? Don't forget to reach out your local legal service organizations. The groups are likely very familiar with laws relating to immigrants in your state. Some legal service organizations can be identified through the Legal Service Corporation website at <http://www.lsc.gov>.
- National Council of La Raza is dedicated to improving the lives of Hispanics in the United States. They are active in addressing congressional legislation regarding immigration issues, and have a great deal of resources for use by advocates focusing on the Hispanic population, including health care information. Visit <http://www.nclr.org>.
- Visit the Health and Human Services' Office of Minority Health (OMH) website at <http://www.omhrc.gov>. OMH is dedicated to improving health care delivery and policy for minorities in the United States.
- You can also go to the Asian & Pacific Islander American Health Forum, a national advocacy organization dedicated to promoting policy, program, and research efforts for the improvement of health status of all Asian American and Pacific Islander communities. Visit <http://www.apiahf.org>.

Making It Understandable: Language Services and Family Planning

Over 44 million Americans speak a language other than English at home. Over 30 million Americans are foreign born, up from 9.6 million in 1970. Three hundred languages are spoken in the United States.³⁸ Lack of interpreters affects the level of health care that non-English speakers receive. Individuals requiring interpreters receive fewer preventive services such as mammography and pap smears, or leave medical visits without understanding how to take medication.^{39, 40} In order to deliver meaningful health care, providers and outreach workers need to find ways to communicate with patients in various languages and respect cultural differences. On the Institute for Reproductive Health Access survey, advocates in states with large populations of non-English speakers often noted that this is a major obstacle in providing family planning care.

Title VI of the Civil Rights Act of 1964

"No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Title VI of the Civil Rights Act of 1964 forbids discrimination against any person on the basis of national origin in offering any services that receive financial assistance.⁴¹ This has been interpreted by the courts to include delivering adequate health services to any individual who does not understand English, including arranging for interpreters, as well as informing patients that interpreters are available. The Balanced Budget Act regulations also require the provision of free oral interpretation services for all Medicaid managed care enrollees.⁴²

Providers may have a legal obligation to provide language interpretation assistance, but it may be difficult for them to get reimbursed for costs. Federal matching funds are available to states for language services provided to Medicaid enrollees. In addition, clinics can use local departments of health, refugee offices, and foundations to access translation services as well. Unfortunately, efforts to get patients translators have been sluggish. While a 1998 study by the National Health Law Program identified 151 state laws that require language services in

health care, states are not ensuring this critical service.⁴³ To date, Medicaid agencies in only six states (Hawaii, Idaho, Maine, Minnesota, Utah, Washington) obtain federal matching payments for language interpretation services provided to Medicaid and SCHIP enrollees.⁴⁴

WASHINGTON STATE

Where Language Barriers Are Not Ignored

Washington is one of the few states that has a program in place to provide translators for health services. The State Department of Social and Health Services created a program that pays interpreters and ensures their quality. Washington contracts with 13 language agencies for services. The agency bills the state, and the state receives partial reimbursement from the federal government.

With a growing population of non-English speakers at Feminist Women's Health Center, it is a top priority to ensure quality translators. Joan Schrammeck, Development and Communications Director, explains that even with the state health program, there are still problems. For example, there is often a delay before a qualified female translator was available. Due to these difficulties, clinics still often use their own funds to finance these services. Between July 2001 and June 2002, the three clinics overseen by the Feminist Women's Health Center provided 348 women with translators and used almost \$27,000 of their own money to do so.

Further, the program has faced continuous threats in the state legislature. This past year, a move to eliminate the program's funding took hold in the legislature; it was thwarted by a coalition including the Washington State Medical Society, the Hospital Association and the interpreters themselves. Its breadth of support results from the fact that coverage for interpreters applies to all health services, not just reproductive health care. General support for translation services, which helps create alliances, has preserved funding for this program.

ADVOCATING FOR BETTER LANGUAGE SERVICES

- What are the rules regarding interpreters? The Center for Medicaid and Medicare Services has created a document to guide advocates and states regarding the requirement to provide interpreters. View *Policy Guidance: Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency* at <http://www.cms.hhs.gov/states/letters/lepguide.pdf>.
- Who is advocating nationally on this issue? The National Health Law Program has created *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* to help providers and advocates understand what must be done to follow the law. NHeLP can also help you find out if your state has a system to provide women enrolled in Medicaid with interpreters, as well as to see if there is any litigation in your state currently underway to ensure access to this services. Visit <http://www.health-law.org/race.shtml#ling>.
- Need to make the case for the need for interpreters in family planning? Visit NARAL's *Language Barriers Hinder Access to Women's Reproductive Health Care* at http://www.naral.org/mediaresources/fact_sheet.html.
- Want more information to back you up? The Access Project's *What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency* demonstrates the undeniable need for states to ensure the availability of translators under the Medicaid program. View at <http://www.accessproject.org/campublications.htm>.
- Are there other advocates focusing on this? The National Limited English Proficient (LEP) Advocacy Task Force may also be helpful in your advocacy efforts. Contact them at <http://www.leptaskforce.org> to find out how they can help.

Getting Women to Family Planning Care: Transportation Services

According to Title XIX of the Social Security Act, state Medicaid programs must ensure “necessary” transportation to and from a Medicaid-covered appointment.⁴⁵ Transportation includes meals and lodging for the client as well as an attendant if necessary. This would include transportation to and from family planning services and even to get a prescription from a pharmacy. States have chosen a number of ways to fulfill this requirement, including reimbursing patients directly and making arrangements with outside transportation agencies. However, advocates in eight states surveyed as part of the Institute for Reproductive Health Access’ survey expressed that lack of transportation was a major barrier to low-income women seeking care. Many states have difficulty getting Medicaid beneficiaries this required service due to lack of knowledge by consumers and providers that the service is available, or barriers in the Medicaid system for approving and paying for transportation.

In some states, Medicaid beneficiaries may be screened to determine if the service is truly necessary, or if reimbursement for travel expenses would be more appropriate.⁴⁶ In case of abortion, this may hinder a woman as she may be unwilling to travel with a friend or relative, due to the personal nature of the service she is seeking. Advocates in some states have formed volunteer networks to help transport women to and from appointments, or get funds to cover transportation.

NEW MEXICO

Family Planning and New Mexico’s Transportation System

Many of New Mexico’s women travel long distances on low budgets to access reproductive health care. The state has only five abortion clinics – three in Albuquerque, one in

Santa Fe, and one in Las Cruces – leaving some counties over 200 miles from a provider. Some women do not have the means to travel these distances. New Mexico ranks 49th in the nation in terms of per capita income, and its median income for a family of four is lowest in the nation. Public transportation is almost non-existent.

Medicaid is required to cover any transportation, meals and lodging necessary for state residents obtaining care in the state. Unfortunately, according to Joan LaMunyon-Sanford, Executive Director of the New Mexico Religious Coalition for Reproductive Choice, most women are unable to get coverage for transportation services when accessing abortion. Sanford believes that a combination of factors is at play. Many Medicaid supervisors do not know about coverage for transportation. Others know, but do not inform women because of the stigma against abortion. Ms. LaMunyon-Sanford notes that Medicaid coverage is advertised for other medical needs, like cancer treatment, but for women seeking abortion, “[people think] they’re too lazy to use their birth control, and now they want a free ride to Albuquerque.” As a result of misinformation, prejudice, and lack of knowledge, eligible women do not access these services.

New Mexico abortion rights advocates hope to improve Medicaid funding for transportation. They are planning to survey patients, providers, and Medicaid staff about problems encountered, educate them about their rights, and work with legal advocates to ensure enforcement of transportation policy. In the meantime, the organization has turned to volunteers to provide rides and home stays when funds are low. Ultimately, they look forward to a time when Medicaid will not only continue to cover abortion services for women, but also cover the transportation services necessary to make access possible.

IMPROVING TRANSPORTATION TO FAMILY PLANNING CARE

- Where can I get more information? The Community Transportation Association has this useful report, *Managing Medicaid Transportation: A Manual Examining Innovative Service Delivery Models Under State Medicaid Managed Care Plans* at <http://www.ctaa.org/pubs/Medicaid>.
- What is the law in your state? The National Health Law Program posts a *Transportation Fact Sheet* on their website. View the fact sheet to find out if your state has a procedure to bring Medicaid recipients to and from appointments, as well as how women can get reimbursed for travel. Visit <http://www.healthlaw.org/medicaid.shtml>.

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Appendix A: The Public Health Care System

Federal and state governments have created a number of funding sources and public health programs through which low-income Americans can obtain family planning services. The following is a brief description of these programs. Visit the websites and publications noted for more detailed information.

Medicaid

Medicaid was created in 1965 as a joint program between the federal and state governments, to provide the lowest-income Americans with health care coverage. In return for federal matching funds, states agree to provide a minimum level of health services to certain populations and help pay for a portion of the cost of the program, between 30 and 50 percent depending on the state. Medicaid programs are administered at the state level, but the Centers for Medicare & Medicaid Services (CMS) – formerly known as the Health Care Financing Administration (HCFA) – a branch of the U.S. Department of Health and Human Services, sets broad rules for states to follow and must approve a state's Medicaid plan as well as any waivers to federal requirements.

MEDICAID: AMERICA'S HEALTH SAFETY NET

Number of Americans covered by Medicaid:
40 million

Number of American women covered by Medicaid:
12 million

Percent of low-income women covered by Medicaid:
34

Number of births that Medicaid covers in the United States:
1 in 3

Number of children covered by Medicaid:
1 in 5

(sources: 47, 48)

See **Protecting Medicaid: America's Health Safety Net** on page 5 and **Enrolling the Eligible** on page 6 for information on advocating around Medicaid.

Federal Medicaid statute sets out broad requirements for state programs, as well as some restrictions. For example, federal statute sets out minimum eligibility for certain populations such as pregnant women and children. If a state agrees to accept federal funding towards a Medicaid program, any individual who falls within these minimum standards is entitled to health coverage under Medicaid including certain guaranteed health services. However, once states comply with the federal requirements, they have broad flexibility to design their Medicaid programs.

Each state determines Medicaid eligibility beyond mandatory levels, the rules by which individuals access services and, to some extent, which services are covered. Thus, there are 50 very different Medicaid programs with widely varying criteria for eligibility and services provided. The complex layers of federal and state law and regulations that define a state's Medicaid program, as well as the various levels of administration, create a complex system for both providers and consumers.

While designed to protect the most vulnerable in society, Medicaid eligibility varies greatly from state to state. In reality, Medicaid leaves many without coverage, including millions of individuals who fall below the federal poverty level.

Medicaid and Abortion Coverage

The Hyde Amendment, enacted by Congress 25 years ago, denied the use of federal Medicaid funds for abortion, except in cases of rape, incest or when the woman's

life is endangered. States have the option of using their own funding, without federal matching funds, to provide coverage for abortion services beyond this level. Currently, only 16 states provide expanded coverage for abortion.⁴⁹

See **Removing the Barriers for Public Funding for Abortion** on page 1 for more information.

Medicaid and Family Planning

Under federal law, Medicaid provides coverage for family planning services. As an incentive for states to cover family planning, the federal government reimburses these services at a 90% rate, as compared to the lower rate of approximately 50% that the federal government uses to reimburse other services.⁵⁰

Which family planning services Medicaid covers is determined by the states. There is no federal definition of “family planning services,” so each state can elect to cover certain contraceptive devices, contraceptive counseling, gynecological exams, STD testing and treatment, sterilization, and other services. In 2001, the Kaiser Family Foundation released the results of a national survey on Medicaid coverage of family planning services. The study found wide disparities in the family planning care covered by state Medicaid programs.⁵¹

WHAT IS LOW-INCOME?

Low-income is defined as having an income less than 200% of the federal poverty level. Poor is defined as having an income below the federal poverty level.

Number of women in the United States:
141 million

Number of low-income American women:
24 million

Number of low-income women without health coverage:
8 million

200% of the federal poverty level for a family of three in 2002:
\$30,040

(sources: 52, 53)

What is Family Planning?

In this document, family planning includes any reproductive health care services, excluding abortion. This includes contraception, sterilization, gynecological care and STD testing and treatment.

RESOURCES ON MEDICAID

- What is Medicaid? The Kaiser Family Foundation offers an easy-to-understand review of Medicaid, covering all the basics, in *Medicaid: A Primer*, available at <http://www.kff.org/content/2001/2248>.
- Need more details? Take a look at the National Health Law Program's *An Advocate's Guide to the Medicaid Program*, a must-have guide for anyone interested in advocating on specific aspects of Medicaid. Information on how to order is available at <http://www.healthlaw.org/advguide/index.shtml>. NHeLP's website also contains information on Medicaid waivers, reproductive health and low-income health advocacy issues.
- Who is eligible for Medicaid? The Center for Medicaid and Medicare Services is the federal agency that oversees Medicaid. They have the latest information on eligibility at <http://cms.hhs.gov/medicaid/eligibility/criteria.asp>.
- The Kaiser Family Foundation has indispensable research on Medicaid and family planning. Look at *Medicaid Coverage of Family Planning Services: Results of a National Survey*, at <http://www.kff.org/content/2001/2216>.

State Children's Health Insurance Program (SCHIP)

In an effort to increase health coverage for children and adolescents, Congress enacted the Balanced Budget Act of 1997 including a new federal-state block grant program allowing states to use federal funding to provide health coverage for children and adolescents. Through the State Children's Health Insurance Program (SCHIP), states have the option of expanding coverage for children through their existing Medicaid program, in a separate stand-alone children's health insurance program, or through a combination of both. The design of each state program is largely determined by the state. Medicaid-based SCHIP programs are run under the Medicaid system and, therefore, generally follow Medicaid levels of coverage. Separate stand-alone SCHIP programs provide states with the opportunity to limit coverage, impose premiums, and identify which services will be covered.

See **Low-Income Adolescents and Reproductive Health Care** on page 14 for information on advocating around SCHIP.

SCHIP gives low-income children health coverage regardless of whether or not their parents have government-sponsored coverage. The program focuses on insuring children in families whose incomes are above the federal poverty level. However, it should be noted that since SCHIP is a block grant, and not an entitlement like Medicaid, states have the option of cutting services as well as capping enrollment.

What Family Planning Services Does SCHIP Cover?

If the state implements its SCHIP program through its existing Medicaid program, then enrollees are guaranteed the same services as regular Medicaid enrollees, including family planning services. SCHIP programs that run separately from the Medicaid system may deny coverage for specific services, including family planning.⁵⁶ This can leave adolescents without access to these critical health services.

SCHIP: COVERING AMERICA'S CHILDREN

Number of children covered under SCHIP in March 2002:
3.8 million

Number of children and adolescents under the age of 18 years without health insurance coverage:
9 million

Percent of uninsured children in the United States eligible for SCHIP or Medicaid:
80

(sources: 54, 55)

RESOURCES ON SCHIP

- The Children's Defense Fund, a leading advocate of health care for children, has created a *SCHIP Toolkit* to help advocates become familiar with the SCHIP program, as well as provides materials to help outreach and enrollment at <http://www.childrensdefense.org>.
- Visit <http://www.insurekidsnow.gov> to link to your specific state SCHIP information, as well as learn basic information about what SCHIP is and who can be covered under this program.
- The Robert Wood Johnson Foundation has a national health access initiative focused on increasing children's access to health care. Find out more at <http://www.coveringkids.org>.
- The Kaiser Family Foundation has updated research on SCHIP programs, enrollment and services. Visit their Medicaid website at <http://www.kff.org/sections.cgi?section=kcmu>.

Title X

Title X is the only funding stream in the United States devoted to family planning services, excluding abortion. Established as part of the Public Health Securities Act of 1970, federal money is funneled out through local agencies to support the delivery of reproductive health care for women who could not otherwise afford it and who are not enrolled in or eligible for Medicaid. Patient costs depend on the individual's income. Women with incomes less than the federal poverty level can access family planning care free of charge. Patients with incomes between 100-250% of the federal poverty level can pay for services on a sliding scale.⁵⁷

TITLE X: FUNDING FOR FAMILY PLANNING

Amount of funding for Title X in 2001:
\$254 million

Number of female clients of Title X supported clinics:
4 million

Percent of U.S. women who obtain birth control
at Title X -sponsored clinics:
15

Estimated number of unintended pregnancies avoided between
1980 and 1999 because of Title X support:
20 million

(sources: 58, 59)

RESOURCES ON TITLE X

- The Alan Guttmacher Institute has done extensive research and reporting on the Title X program. They have a number of resources that are excellent for advocates looking to learn more about the program including *Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics and Issues in Brief: Title X: Three Decades of Accomplishment*, available at <http://www.guttmacher.org>.
- Planned Parenthood Federation of American advocates heavily for Title X funding, as the majority of local Planned Parenthood clinics receive this federal funding. Their publication *America's Family Planning Program: Title X* gives excellent background information, at <http://www.plannedparenthood.org/library>.

Title V

The Maternal and Child Health Block Grant, Title V of the Social Security Act, provides block grants to states for maternal and child health care. Some states allocate a portion of their Title V funding towards reproductive health care.⁶⁰

Title XX

The Social Services Block Grant, known as Title XX, is used by eleven states to provide family planning services. Grants are provided to state social service agencies, and can be used towards programs that will help low-income individuals gain financial independence. Some states use these funds to support family planning.⁶¹

State Funds

State taxpayer dollars are also used to support family planning services. In a national survey by the Kaiser Foundation, providers in 34 states reported receiving state funding.⁶²

Welfare Dollars

In the 1996 welfare overhaul, states began receiving funding in the form of block grants, under the Temporary Assistance for Needy Families (TANF) program. These funds can be used by states to pay for family planning care. According to the Kaiser Foundation, eleven states have used these funds to provide family planning care to women on public assistance.⁶³

RESOURCES ON BLOCK GRANTS

- Find out more about the Maternal and Child Health Block Grants (Title V) at <http://www.mchdata.net>
- The Alan Guttmacher Institute's *Block Grants are Key Sources of Support for Family Planning* gives an excellent background on both Title V and Title XX at <http://www.guttmacher.org>.
- Information on Title XX is also available at <http://www.acf.dhhs.gov/programs/ocs/ssbg>.
- For more information on welfare, visit The Center for Law and Social Policy at <http://www.clasp.org>, as well as the Center for Budget Policy and Priorities at <http://www.cbpp.org>.

Appendix B:

Reproductive Health Care and Legal Services:

Demystifying the Legal Service Corporation Rules

Written by Lourdes A. Rivera,
Managing Attorney, National Health Law Program

Widespread confusion and misinterpretation of rules has often made legal services groups reluctant or wary to work on reproductive health issues. Legal services organizations can work on reproductive health access issues as part of their broader health care activities. This analysis seeks to encourage this work and provide clearer parameters for legal services programs. We also hope to encourage working with other potential allies who have more flexibility to advocate for services, which are needed by the client community.

This analysis grows out of a survey undertaken by the National Health Law Program (NHHeLP) of legal services programs across the nation. Most legal service programs that responded to the survey indicated that they did not work on family planning issues at all – or only worked on a limited scope of services, such as on access to breast and cervical cancer treatment.

Among the most common reasons for the absence of activity in this area were the program's interpretation of Legal Service Corporation restrictions; confusion and fear about what the program can do regarding reproductive health services; the fact that clients do not raise these issues with the program; the issue is not a priority within the program; and/or not enough staff to take on these issues. Among those programs indicating that clients are not raising this issue, the programs noted that they have not done much outreach and education on these issues; the programs have not worked with other groups, such as Planned Parenthood, that can refer these cases to the program; the community associates the program with other health issues; and/or that clients do not understand that these are issues that a lawyer can help with.

This analysis identifies areas in which legal services attorneys can legally and appropriately advocate on behalf of clients needing access to reproductive health services as well as those areas that clearly are prohibited. We also have identified issues and activities for which there is room for interpretation. The analysis provides the alternative rationales and suggests a cautious approach.

Legal Services Programs Should be Helping Clients Access Needed Reproductive Health Services

In 1974, Congress enacted the Legal Services Corporation Act, 42 U.S.C. §§ 2996 et seq¹. Under the Act, the LSC, a non-profit corporation, awards annual funds received from Congress to local programs “for the purpose of providing financial support for legal assistance in noncriminal proceedings... to persons financially unable to afford legal assistance.” *Id.* § 2996b.

LSC funding recipients must abide by certain restrictions under the Act. For example, LSC funds may not be used to provide legal assistance in any fee generating case or for any political activities.² Additional restrictions have been attached by Congress in the annual budget appropriations for LSC funds.³

Other than for abortion, there are no restrictions on the legal advocacy that LSC programs can provide to individual clients and client communities, except for the generally applicable LSC restrictions. Reproductive health services for which LSC funded advocates can work on include a broad range of services, including family planning; sterilization; prevention, identification and treatment of sexually transmitted infections and HIV/AIDS; fertility services; breast and gynecological cancer screening and treatment; and other services. Many activities related to abortion also are legally and technically permitted. However, LSC programs should be aware that abortion-related work is controversial and could result in significant political consequences and raise scrutiny. Thus, programs should weigh the risks, the individual client and community needs, and other available community resources. While the abortion issues merit a cautious, case-by-case approach, LSC programs should not be discouraged from addressing the reproductive health needs of their clients and from working with others who can be more inclusive of abortion issues. We encourage programs that are faced with making these judgments to contact the Center for Law and Social Policy (CLASP) or NHHeLP for further assistance in interpreting LSC rules as they relate to reproductive health issues.⁴

Non-Abortion Reproductive Health Services

Other than restrictions that generally apply to LSC funding recipients (e.g. restrictions on grass roots lobbying, class actions, etc), there are no other restrictions on LSC funded activities to help clients obtain access to reproductive health services that are not abortion. Thus, legal services attorneys can engage in the full range of activities to help individuals obtain family planning, sterilization, STD and HIV/AIDS prevention and treatment and other services. There is a strong argument that emergency contraception should be included among family planning services.⁵ A court in California has held that emergency contraception is a form of pregnancy prevention and not an abortifacient.⁶ However, there is no indication of LSC's position on this issue.

Activities Related to Abortion

Except for litigation and proceedings, there are no other specific restrictions on work related to abortion issues. Thus, for example, LSC recipients could provide clients with counsel or advice about their legal rights to access these services. LSC programs also can use non-LSC funds to respond to a written request for information or testimony from a legislative body, committee, a legislator or a government agency, and can participate in a public rulemaking process.⁷

Abortion Litigation

LSC-funded programs may not participate in any abortion litigation. This ban applies to both LSC funds and non-LSC funds. However, tribal funds are not similarly restricted and can be used for the purposes for which they were provided.⁸

Abortion "Proceedings"

LSC programs also may not use LSC funds to provide legal assistance related to proceedings which seek to procure a non-therapeutic abortion or to compel any individuals or institutions to perform abortions that are contrary to their religious or moral beliefs.⁹

Restrictions on Non-LSC Funding Sources

It is not clear whether this same restriction applies to non-LSC funds. Section 504(d)(B) of the appropriations act of 1996 prohibits the use of non-LSC funds for "any purpose prohibited by ... the [LSC] Act." This provision has been incorporated into every subsequent LSC appropriations statute.¹⁰

There are two possible interpretations of the statute. Under the first interpretation, LSC programs can use public and IOLTA funds to participate in such proceedings, as long as the funds are expended for the purposes for which they were awarded.¹¹ The reasoning under this interpretation is that non-LSC funds can be used for purposes for which the LSC Act itself imposes no restrictions on non-

LSC funds. The LSC Act does not restrict the use of non-LSC funds for abortion proceedings. This interpretation is consistent with current LSC regulations.¹²

Another possible and a more conservative interpretation would extend the restrictions imposed on LSC funds to other funds as well. Either of these interpretations may be technically correct. However, LSC programs faced with this question should contact CLASP for assistance in assessing the circumstances.

"Compelling" an Abortion

Participation in proceedings is prohibited for the purpose of compelling an individual or institution to provide an abortion when doing so is contrary to their religious or moral beliefs.¹³ Thus, for example, an LSC program may not file a proceeding to compel a religious HMO or hospital or an individual provider to provide or assist in an abortion.

Procurement of "non-therapeutic" abortion

LSC programs also may not be involved in proceedings for the purpose of procuring a "non-therapeutic" abortion. This term is not defined in the statute or regulations.¹⁴ However, legislative history provides some guidance on the Congressional intent of the meaning of "therapeutic" abortions as those that are medically necessary to the treatment of a serious physical injury or illness.¹⁵ Thus, mental health reasons would not be sufficient.

Scope of "proceeding"

The term "proceeding" as it relates to the abortion restriction is not defined either in statute or regulations. The term is defined by LSC only in the regulations with respect to criminal proceedings in which LSC programs may not participate. Section 1613.2 of 45 C.F.R. defines a criminal proceeding as:

the adversary judicial process prosecuted by a public officer and initiated by a formal complaint, information, or indictment charging a person with an offense... A misdemeanor or lesser offense tried in an Indian tribal court is not a "criminal proceeding."

In 45 C.F.R. § 1637.3, LSC also distinguishes civil litigation on behalf of a prisoner and administrative proceedings challenging the conditions of incarceration as prohibited activities, but does not prohibit other types of administrative proceedings. Thus, under these LSC pronouncements, an arguable interpretation of proceedings is actions in which litigation or court action is filed.

However, a more common definition would include administrative proceedings, such as fair hearings. For example, Black's Law Dictionary 1204 (6th ed. 1990) defines "proceeding":

In a general sense, the form and manner of conducting judicial business before a court or judicial officer. Regular and orderly progress in form of law, including all possible steps in an action from its commencement to the execution of judgment. Term also refers to administrative proceedings before agencies, tribunals, bureaus, or the like.

Because of the general definition in Black’s and the ambiguity of the term in LSC rules, a cautioned approach may be to refrain from participating in administrative hearings, such as fair hearings, for the purpose of procuring a non-therapeutic abortion or to compel the individuals or institutions to provide abortions who refuse or object to doing so based on religious or moral beliefs. Again, programs considering this action should contact CLASP for assistance.

However, this term does not seem to preclude LSC program assistance in a managed care internal grievance procedure because there is no involvement of a judicial officer, a court or an agency. Thus, an internal grievance procedure to challenge a prior authorization denial or delay, for example, would not be prohibited.

Summary of Permitted Activities

Except for restrictions that apply to all of LSC-funded program work (i.e. no class actions), there are no restrictions on the use of LSC or other funding sources to help clients obtain non-abortion reproductive health services (e.g., family planning, sterilizations, STD screening and treatment, etc). Thus, LSC programs can and should engage in all otherwise permissible activities to help clients gain access to these services.¹⁶

With respect to abortion, LSC-funded programs may provide some services with LSC funds (e.g., client education and advice about legal rights) and with non-LSC funds (e.g., responding to a written request from a legislature or agency). LSC programs may not use LSC funds to participate in proceedings to assist individuals procure “non-therapeutic” abortions or to compel an individual or facility to provide an abortion if doing so would be contrary to a religious or moral belief. It is not clear whether such activity would be permitted using non-LSC funds. The alternative interpretations are discussed below. Abortion-related litigation is not permitted under any circumstances.

Activity	Abortion – LSC Funds	Abortion – Non-LSC Funds	Non-Abortion Reproductive Health Services
Litigation	No	No	Yes
Proceeding	No*	Maybe	Yes
Other activities as permitted by general LSC restrictions	Yes <i>(e.g. information, advice on legal rights)</i>	Yes <i>(e.g. participate in rulemaking, responding to written requests by legislators)</i>	Yes

* Proceedings are not permitted if they are for the purpose of assisting individuals procure non-therapeutic abortions or to compel individuals or institutions to provide abortions

¹ Pub.L.93-355,88 Stat.378.

² 42 U.S.C. § 2996f(b); 2996e. Federal regulations implementing these restrictions were promulgated at 41 Fed.Reg.25899 (1976) and revised in 1997 at 62 Fed. Reg.19398 (1997) to amend the fee generating case rules.

³ See, e.g., Department of Commerce, Justice, and State, the Judiciary and Related Agencies Appropriations Act of 1989, Pub. L.No.100-459, § 605, 102 Stat.2186, 2227 (1988); Omnibus Consolidated Rescission and Appropriations Act of 1996, § 504, Pub.L.104-134, 110 Stat.1351, 1321-53. Note that the Supreme Court has struck down the 1996 Appropriations Act provision prohibiting LSC funded programs from challenging the statutory or constitutional validity of welfare laws. Thus, LSC recipients can raise all legal challenges in seeking relief for individual clients who are adversely affected by welfare reform laws, regulations, or policies. *Legal Services Corp. v. Velasquez*, 121 S.Ct.1043 (2001).

⁴ CLASP can be contacted at (202) 328-5146 or at lperle@clasp.org. NHeLP would like to acknowledge CLASP’s assistance in developing this analysis.

⁵ The National Institutes of Health, the American Medical Association, and the American College of Obstetricians and Gynecologists view emergency contraception as a contraceptive and not an abortifacient. Emergency contraception can be administered and is effective within 72 hours of unprotected sex. It is not effective once pregnancy has occurred. Under the standard medical definition, pregnancy occurs when a fertilized egg is implanted in the uterine wall. An anti-abortion group in Ohio has filed a claim in federal district court on behalf of a pharmacist arguing that dispensing emergency contraception is the equivalent of abortion because pregnancy occurs at the point of fertilization.

⁶ *Brownfield v. Daniel-Freeman Hospital*, 208 Cal. App.3d 405 (1989).

⁷ For more information on LSC permissible activities and restrictions, see, e.g., Alan W. Houseman, *Racial Justice: The Role of Civil Legal Assistance*, 36 CLEARINGHOUSE REVIEW 5 (May-June, 2002); Camille D. Holmes, et al., *Race-Based Advocacy: The Role and Responsibility of LSC-Funded Programs*, 36 CLEARINGHOUSE REVIEW 61 (May-June, 2002).

⁸ 45 C.F.R. § 1610.4.

⁹ 42 U.S.C. § 2996f(b)(8). This restriction also applies to the use of private funds. 45 C.F.R. § 1610.4(c).

¹⁰ See e.g., Pub.L.106-553, 114 Stat.2762A-101 (incorporating § 502, Pub.L.105-119, 111 Stat.2510-2511, which in turn incorporates § 504, Pub.L.104-134, 110 Stat.1321-53 et seq. Section 504(d)(2)(B) prohibits the use of non-LSC funds for purposes prohibited by the LSC Act.

¹¹ *C.f. National Center for Youth Law v. Legal Services Corporation*, 749 F. Supp.1013, 1017-18 (N.D. Cal. 1990) (where California IOLTA funds were awarded for the purposes of providing legal services to indigent clients and for providing special services on matters of specialized substantive law important to the recipient’s special client group (e.g., indigent minors), use of IOLTA funds was not improper to participate as Amici in a case challenging the constitutionality of a parental consent abortion law).

¹² 45 C.F.R. § 1610.4(b) (“a recipient may receive public or IOLTA funds and use them in accordance with the specific purposes for which they were provided, if the funds are not used for any activity prohibited by or inconsistent with Section 504”).

¹³ 42 U.S.C. § 2996f(b)(8).

¹⁴ The term also is no longer used in the medical community.

¹⁵ See e.g., 131 Cong. Rec.S14613 (daily ed. Nov. 1, 1985, legislative day of Oct. 28, 1985) (statement of Sen. Humphrey); 133 Cong. Rec.S2625 (daily ed. Feb 26, 1987) (statement of Sen. Humphrey). See also *Letter to John Francis O’Toole, National Center for Youth Law, from Legal Services Corporation* (Oct. 20, 1998) (citing to 120 Cong. Rec.H3945-3955 (daily ed. May 16, 1974) (remarks by Congressman Froehlich) to conclude that “[t]he exception for therapeutic abortions must accordingly be constrained to circumstances where abortion is necessary and integral to the treatment of a serious existing physical injury or illness.”)

¹⁶ For a broad discussion on legal services permissible activities and restrictions, see *supra* note 7.

¹⁷ Such as IOLTA, tribal, and public funds that are expended in accordance with the purposes for which they were provided.

Appendix C:

Organizations and Resources

The Alan Guttmacher Institute (AGI)

<http://www.guttmacher.org>
info@guttmacher.org
 New York Office (212) 248-1111
 Washington, D.C. Office (202) 296-4012
 AGI has done critical research in all areas of family planning, including support for Title X funding, public funding for abortion and Medicaid.

American Civil Liberties Union (ACLU)

<http://www.aclu.org>
 (212) 549-2500
 The ACLU has extensive information on the legal history of abortion rights and family planning and is actively working to ensure the continuation of these legal rights.

Association of Reproductive Health Professionals

<http://www.arhp.org>
 (202) 466-3825
 ARHP is a multidisciplinary association of professionals who provide reproductive health services or education, conduct reproductive health research, or influence reproductive health policy.

C.A.R.E.2000 (Coalition for Access and Reproductive Equity)

<http://www.care2000.org>
carecampaign@aol.com
 (202) 543-7140
 C.A.R.E.2000 is a national coalition of organizations devoted to increasing access to reproductive health care for low-income women, women of color and young women. C.A.R.E.2000 is a project of the National Network of Abortion Funds. C.A.R.E.2000 is running a national campaign focused on the repeal of the Hyde Amendment.

Catholics for a Free Choice

<http://www.catholicsforchoice.org>
cffc@catholicsforchoice.org
 (202) 986-6093
 Catholics for a Free Choice has done outstanding research on the availability of family planning services in Catholic health systems, including Catholic Medicaid managed care plans.

Center on Budget and Policy Priorities

<http://www.cbpp.org>
 (202) 408-1080
 A leading organization working on fiscal issues and policy affecting low-income individuals.

The Center for Law and Social Policy (CLASP)

<http://www.clasp.org>
 (202) 906-8000
 CLASP is dedicated to work on family policy and access to civil legal assistance for low-income families. They have an excellent research and policy papers regarding Welfare and TANF, as well as reproductive health care. Their work also includes "general counsel" to LSC-funded programs and the Project on the Future of Legal Services.

Centers for Medicare and Medicaid Services (CMS)

<http://www.cms.gov>
 (410) 786-3000
 CMS is the division of the U.S. Department of Health and Human Services which oversees Medicaid at the federal level.

Center for Reproductive Law and Policy (CRLP)

<http://www.crlp.org>
info@crlp.org
 (917) 637-3600
 The legal experts of the pro-choice movement, CRLP is actively involved in defending reproductive rights in the courts across the country.

Children's Defense Fund

<http://www.childrensdefense.org>
cdfhealth@childrensdefense.org
 (202) 628-8787
 The Children's Defense Fund has a campaign devoted to ensuring and expanding health care for children through SCHIP. They have information on state contacts for advocating around children's health issues, as well as updates on recent developments.

Families USA

<http://www.familiesusa.org>
info@familiesusa.org
 (202) 628-3030
 Families USA is dedicated to promoting comprehensive health care for all Americans. The largest and most powerful coalition for access to low-income health care, Families USA is an excellent resource on congressional actions. Their advocacy toolkits are outstanding, comprehensive resources.

The Henry J. Kaiser Family Foundation

<http://www.kff.org>
 California Office (650) 854-9400
 Washington, D.C. Office (202) 347-5270
 The Kaiser Foundation is one of the leading research organizations for a number of health care areas including Medicaid, family planning and other public health care programs. Their regular publications and studies have looked at public health programs from every angle, and provide the necessary information for advocates to move their work forward.

Institute for Reproductive Health Access

<http://www.naralny.org>
irha@naralny.org
 (212) 343-0114
 The Institute for Reproductive Health Access, the national training arm of the NARAL/NY Foundation, provides technical support in a collaborative effort with other state and national organizations by helping with research, developing results-oriented strategies and supporting the implementation of their program ideas. The Low-Income Access Project seeks to ensure access to comprehensive reproductive health care for low-income Americans through public health care systems.

Institute of Medicine

<http://www.iom.edu>
(202) 334-2352

The mission of the Institute of Medicine is to advance and disseminate scientific knowledge to improve human health, and have published numerous reports on the status of the uninsured.

National Abortion Federation (NAF)

<http://www.prochoice.org>
(202) 667-5881

NAF is the professional association of abortion providers in the United States and Canada.

National Abortion and Reproductive Rights Action League (NARAL)

<http://www.naral.org>
(202) 973-3000

NARAL is dedicated to protecting and expanding reproductive health care, and is a leader in advocating for this care at the national level.

National Coalition of Abortion Providers (NCAP)

<http://www.ncap.com>
(703) 684-0055

NCAP is a pro-choice organization that represents the political interests of over 150 independent abortion providers throughout the United States.

National Council of La Raza

<http://www.nclr.org>

NCLR is a non-profit organization dedicated to improving the well-being of Hispanic Americans.

National Family Planning and Reproductive Health Association

info@nfprha.org
<http://www.nfprha.org>
(202) 293-3114

A national non-profit membership organization, NFPRHA represents virtually the entire domestic family planning field, including clinicians, administrators, researchers, educators, advocates and consumers.

National Health Law Program (NHLP)

<http://www.healthlaw.org>
nhelp@healthlaw.org

California Office (310) 204-6010

Washington, D.C. Office (202) 289-7661

The National Health Law Program is a national public interest law firm working to increase and improve access to quality health care on behalf of limited income people by providing legal and policy analysis, advocacy, information and education. Their website contains a special section devoted to new Medicaid waivers, as well as comprehensive legal information regarding Medicaid law and application.

National Immigration Law Center

www.nilc.org
(213) 639-3900

NILC is dedicated to protecting and ensuring the rights of low-income immigrants and their families. Look for their materials on access to interpreters, as well as the rights of immigrants to health coverage.

National Institute of Health (NIH)

<http://www.nih.gov>
NIHInfo@od.nih.gov

Office of Research on Women's Health <http://www4.od.nih.gov/orwh>

The NIH has extensive medical research that may be critical in collecting information for health advocacy.

National Network of Abortion Funds (NNAF)

<http://www.nnaf.org>
info@nnaf.org

(413) 559-5645

NNAF, an association of abortion funds in the United States, provides financial and technical support to local abortion funds, and aids in the creation of new abortion funds. Their website provides a state-by-state contact list of funds which can be contacted for support of local efforts.

National Partnerships for Women and Families (NPWF)

<http://www.nationalpartnership.org>
info@nationalpartnership.org

(202) 986-2600

NPWF uses public education and advocacy to promote fairness in the workplace, quality health care, and policies that help women and men meet the dual demands of work and family.

National Women's Law Center

<http://www.nwlc.org>
info@nwlc.org

(202) 588-5180

Advocates to protect and expand women's and children's rights in a number of different areas including reproductive health care.

Medical Students for Choice

<http://www.ms4c.org>
(510) 238-5210

MSFC is dedicated to ensuring that women receive the full range of reproductive health care choices. They work to make reproductive health care, including abortion, a part of standard medical education and residency training.

MergerWatch

<http://www.mergerwatch.org>
info@mergerwatch.org

(518) 436-8408

MergerWatch is actively involved in monitoring mergers between secular and religiously affiliated institutions in which access to family planning services may be threatened.

Physicians for Reproductive Choice and Health

<http://www.prch.org>
(646) 366-1890

PRCH enables concerned physicians to take a more active and visible role in support of comprehensive reproductive health care.

Planned Parenthood Federation of America (PPFA)

<http://www.plannedparenthood.org>

New York Office (212) 541-7800,

Washington, D.C. Office (202) 785-3351

Planned Parenthood is one of the largest providers of reproductive health care nationwide, with over 850 clinics across the country. These clinics are often the leaders of pro-choice advocacy in communities and are intimately familiar with local policy and barriers.

The Robert Wood Johnson Foundation

<http://www.rwjf.org>

A foundation and advocacy organization dedicated to expanding and improving health care. Their website, <http://www.coveringkids.org>, is an excellent resource for advocates interested in increasing children's access to health care.

Universal Health Care Action Network

uhcan@uhcan.org
<http://www.uhcan.org>

(800) 634-4442

UHCAN works to achieve universal health care in the United States. They have a great many resources that can be used to promote increased access to care.



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462 Broadway, Suite 540
New York, NY 10013
T. 212-343-0114
F. 212-343-0119
IRHA@naralny.org
www.naralny.org

National Health Law Program
2639 S. La Cienega Blvd.
Los Angeles, CA 90034
T. 310-204-6010
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nhelp@healthlaw.org
www.healthlaw.org