Planned Parenthood® of Southern New England, Inc.

Yale SCHOOL OF PUBLIC HEALTH

Examining the Effectiveness of Connecticut's Medicaid Family Planning Limited Benefit Program

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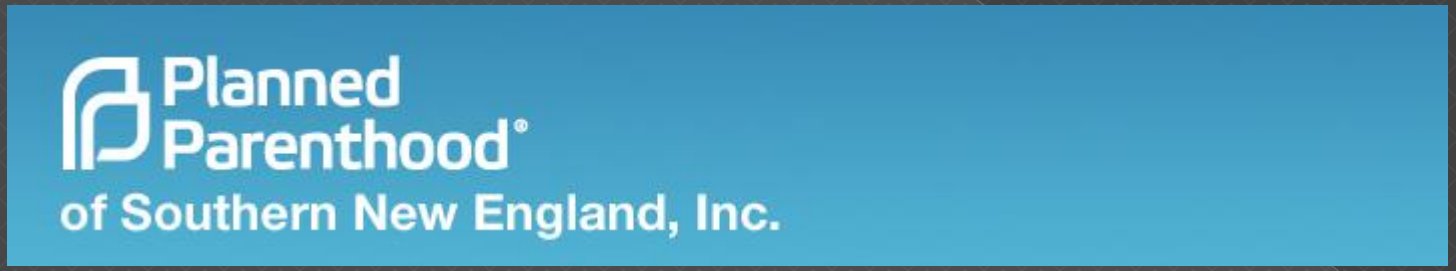
Introduction

- Approximately half of the 6.6 million pregnancies in the United States each year are unintended, resulting in births, abortions, miscarriages[1]
- Births that result from unintended pregnancies can lead to adverse maternal and child health outcomes[2,3,4]
- Many women are unable to afford contraception[5]

- Nearly half of the childbirths in the U.S. are paid for by Medicaid (45%)[1]
  - One Medicaid birth costs close to $10,500, as estimated by the Guttmacher Institute[6]
- In 2008, over 51% of pregnancies in Connecticut were reported as unintended[7]
  - Cost $93M to federal and state government[7]

- Medicaid family planning expansion programs have been shown be successful in other states
  - TAKE CHARGE in Washington[8]
  - California[8]
- Connecticut implemented MFPE in 2012 for men and women of reproductive age whose income is at or below 250% of the Federal Poverty Level (FPL)[9]

- 90% of enrollment in the Connecticut's MFPE program occurs through Planned Parenthood of Southern New England (PPSNE)[9]
  - Over 5,000 new participants since program began



Aim 1: Examine likelihood of switching to more effective contraceptive methods among those in the MFPE group compared to the Self-Pay group

- Hypothesis: Women in the MFPE group are more likely to switch to more highly effective contraceptive methods

Aim 2: Estimate rates of unintended pregnancies among those who enrolled in MFPE compared to the Self-Pay group

- Hypothesis: Rate of UP in the MFPE group is lower than the Self-Pay

Aim 3: determine cost savings in terms of births averted and costs saved to CT Medicaid

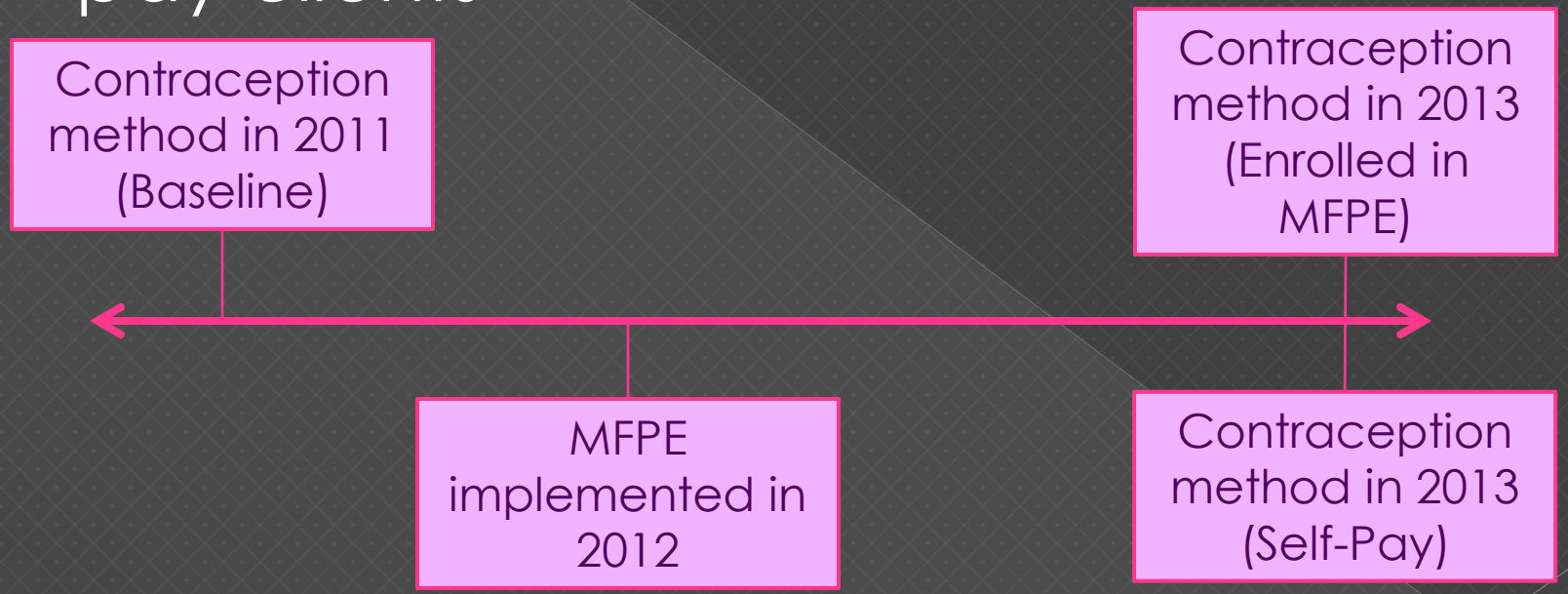
- Hypothesis: the MFPE program will result in substantial costs saved to CT Medicaid

Study population

- PPSNE provided data for women that enrolled in MFPE and that remained self-pay clients
  - Age, race, weekly income, % of federal poverty level, center attended
  - Contraception method in 2011 and 2013
  - Excluded women not of reproductive age, pregnant or seeking pregnancy or above 250% of federal poverty level

Study population

- PPSNE provided data for women that enrolled in MFPE and that remained self-pay clients



Predictors of contraception use

- Multivariate logistic regression
- Predictors: Medicaid Expansion enrollment status, age, race, income, contraception method 2011
- Outcome: Highly effective contraception use in 2013

Highly Effective[12]

Intrauterine device
Depo-Provera
Sub-dermal implant
Hormonal patch
Oral contraception
Nuva-Ring
Abstinence

Not Highly Effective[12]

Condoms
Diaphragm
Withdrawal
Rhythm method
No method

Models from Guttmacher Institute[6,10]

Method	Number of Women	Failure Rate of Method (%)	Expected Number of Pregnancies (Number x Failure Rate)
IUD	39	0.8	0.312
Depo	138	6	8.28
Patch	16	9	1.44
Nuva-Ring	54	9	4.86
OCP	497	9	44.7
Condom	247	18	44.5
Abstinence	12	0	0
Implant	11	0.05	0.006
Spermicide	1	28	0.28
Withdrawal	2	22	.44
None	136	85	115.6
	Total in 2011		**220.418 pregnancies**

(Pregnancies in 2011)-(Pregnancies in 2013)=**Pregnancies Averted**

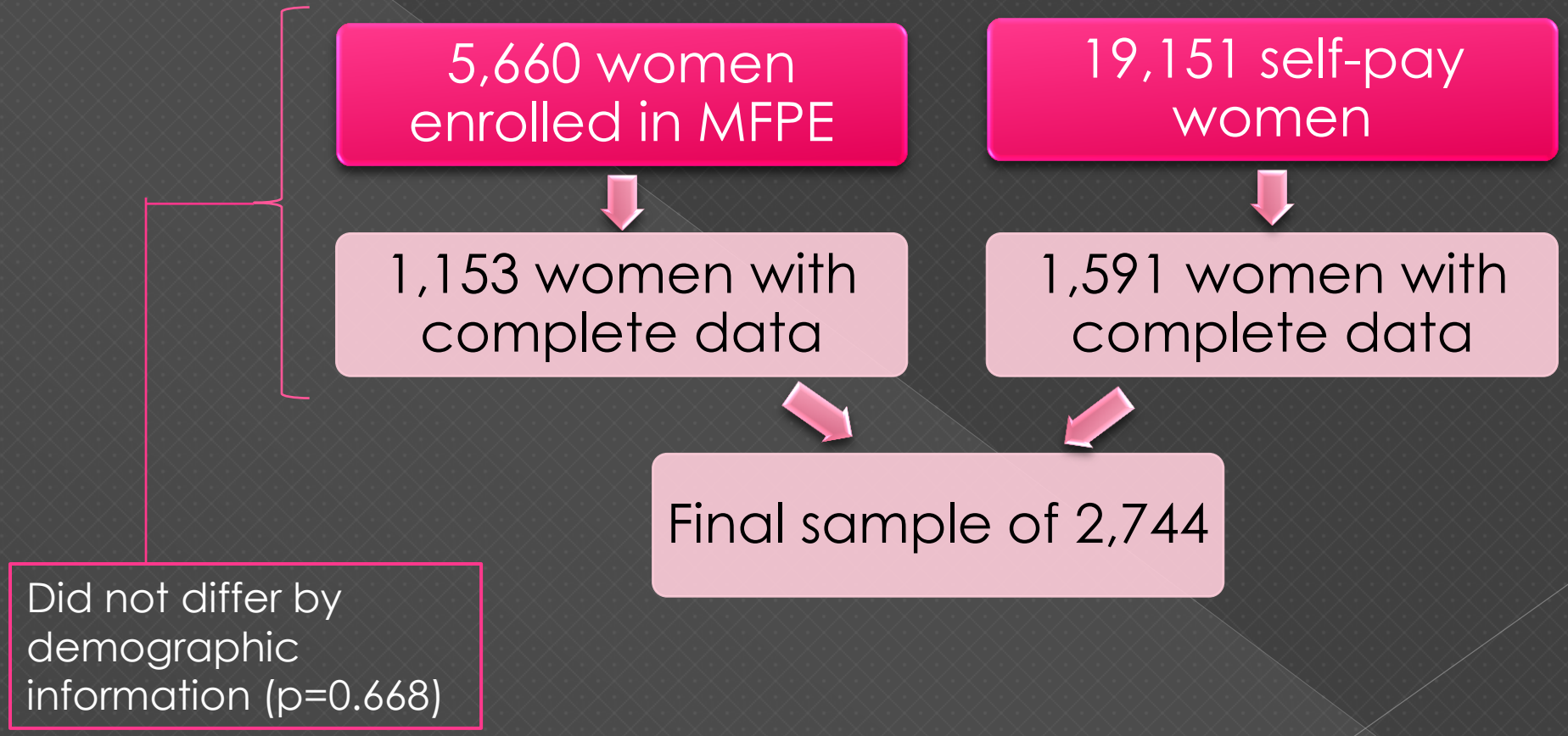
Outcome	Connecticut Specific Proportion[11]
Birth	37%
Abortion	51%
Miscarriage	12%

Pregnancies averted*0.37=**Births averted**
Pregnancies averted*0.51=**Abortions averted**
Pregnancies averted*0.12=**Miscarriages averted**

Cost of Medicaid Birth in Connecticut[6]	$10,411

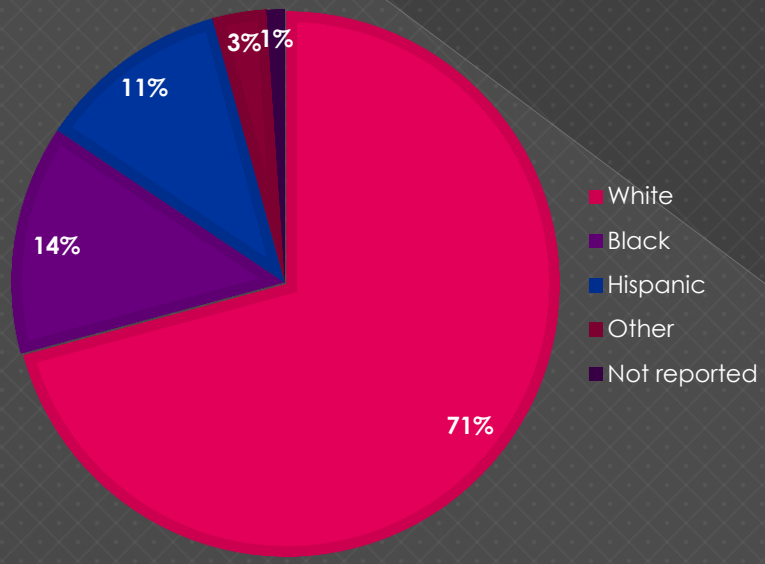
Births averted*10,411=**State funds saved**

Results


5,660 women enrolled in MFPE
19,151 self-pay women
1,153 women with complete data
1,591 women with complete data
Final sample of 2,744
Did not differ by demographic information (p=0.668)

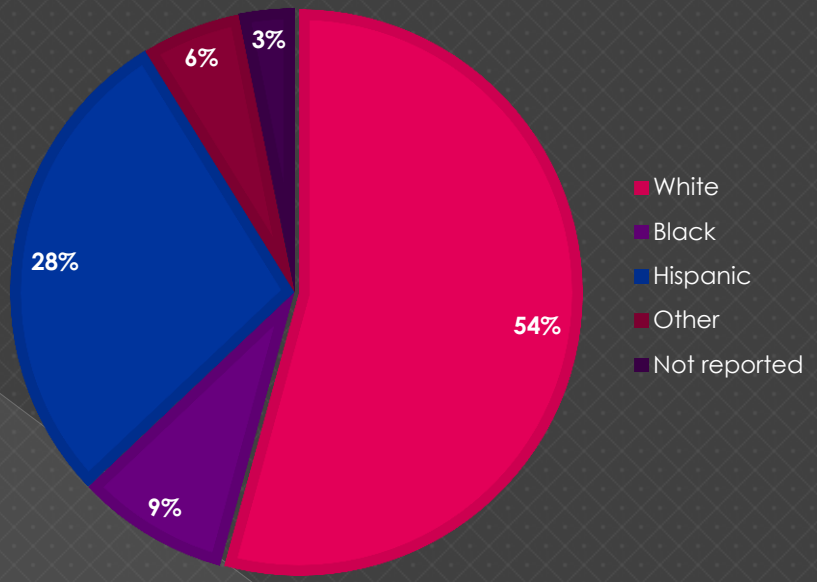
Hispanic women were disproportionately underrepresented in MFPE enrollment in 2013, p<0.001

RACIAL BREAKDOWN, MFPE ENROLLEES



Age (years)	25.9 ± 5.4
Family Size	1.3 ± 0.8
Weekly Income ($)	281.4 ± 129.7

RACIAL BREAKDOWN, SELF-PAY CLIENTS



Age (years)	27.0 ± 6.5
Family Size	1.7 ± 1.2
Weekly Income ($)	288.9 ± 151.8

MFPE women were **7.16** *times more likely* to choose highly effective contraception when compared to self-pay clients

Predictor	Odds Ratio (95% CI)
MFPE vs. Self -Pay	**7.16 (5.76, 8.90)***
Income Level: 101%-138% vs. <100%	0.90 (0.73, 1.11)
Income Level: 139%-150% vs. <100%	0.60 (0.31, 1.15)
Income Level: 150%-200% vs. <100%	0.89 (0.66, 1.21)
Income Level: 200%-250% vs. <100%	1.14 (0.72, 1.80)
Non– Hispanic Black vs. White	**0.58 (0.42, 0.79)***
Hispanic vs. White	1.12 (0.88, 1.42)

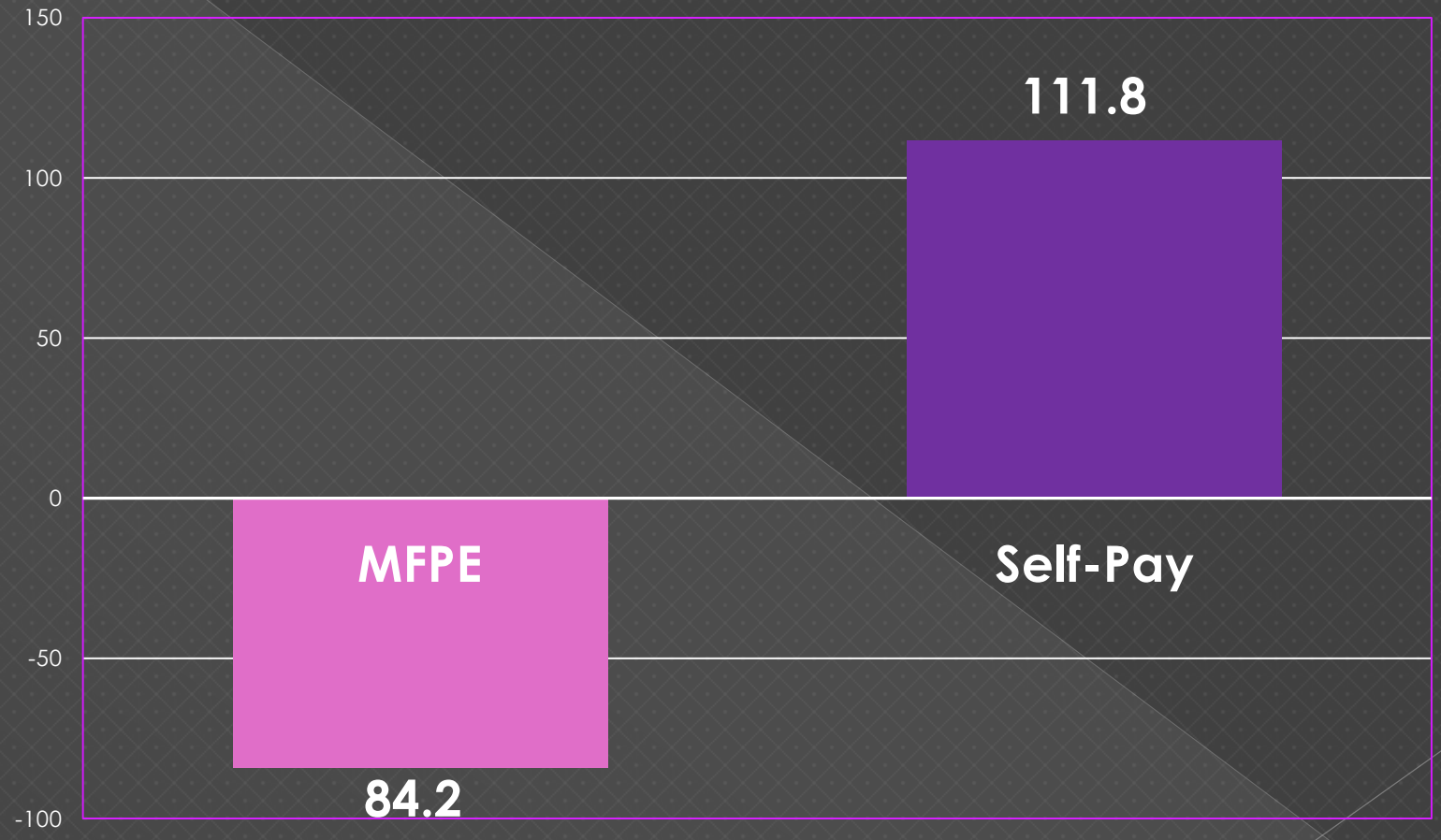
Non- Hispanic Black women were 42% less likely to choose highly effective contraception, when compared to White women

MFPE does not reduce disparity between black and white women

Predictor	Odds Ratio (95% CI)
Self-Pay	
Non– Hispanic Black vs. White	0.57 (0.37, 0.90)
MFPE	
Non– Hispanic Black vs. White	0.53 (0.33, 0.86)

The odds of using a highly effective method of contraception for black women compared to white women are similar in both groups

Estimated Unintended Pregnancies in MFPE vs. Self-Pay, from 2011- 2013



Estimated Reproductive Events Averted Through MFPE

Unintended Events Averted	Per 1,153 women with complete data	For every 100 women enrolled	For all 5660 women enrolled
Pregnancies	84.2	7.3	413.4
Abortions	42.9	3.7	210.8
Miscarriages	10.1	0.88	49.6
Births	31.2	2.7	153.0
Cost Savings	**$324,379**	**$28,133.50**	**$1,592,350**

Conclusions

- Results support PPSNE's continued enrollment of women in MFPE
  - Potential decrease in rates of UP and unintended births and funds saved
- Participants in the MFPE group were more likely to switch to a more effective birth control method than women in the self-pay group

- Estimates of pregnancies averted and cost savings only reflect the first 2 years of the MFPE program
  - with continued investment, MFPE may be a cost-effective option for participants, Medicaid, and Connecticut policy makers

Limitations

Numbers are estimates since no data that link enrollees of MFPE to the outcomes of pregnancy or birth, or actual births covered by Medicaid

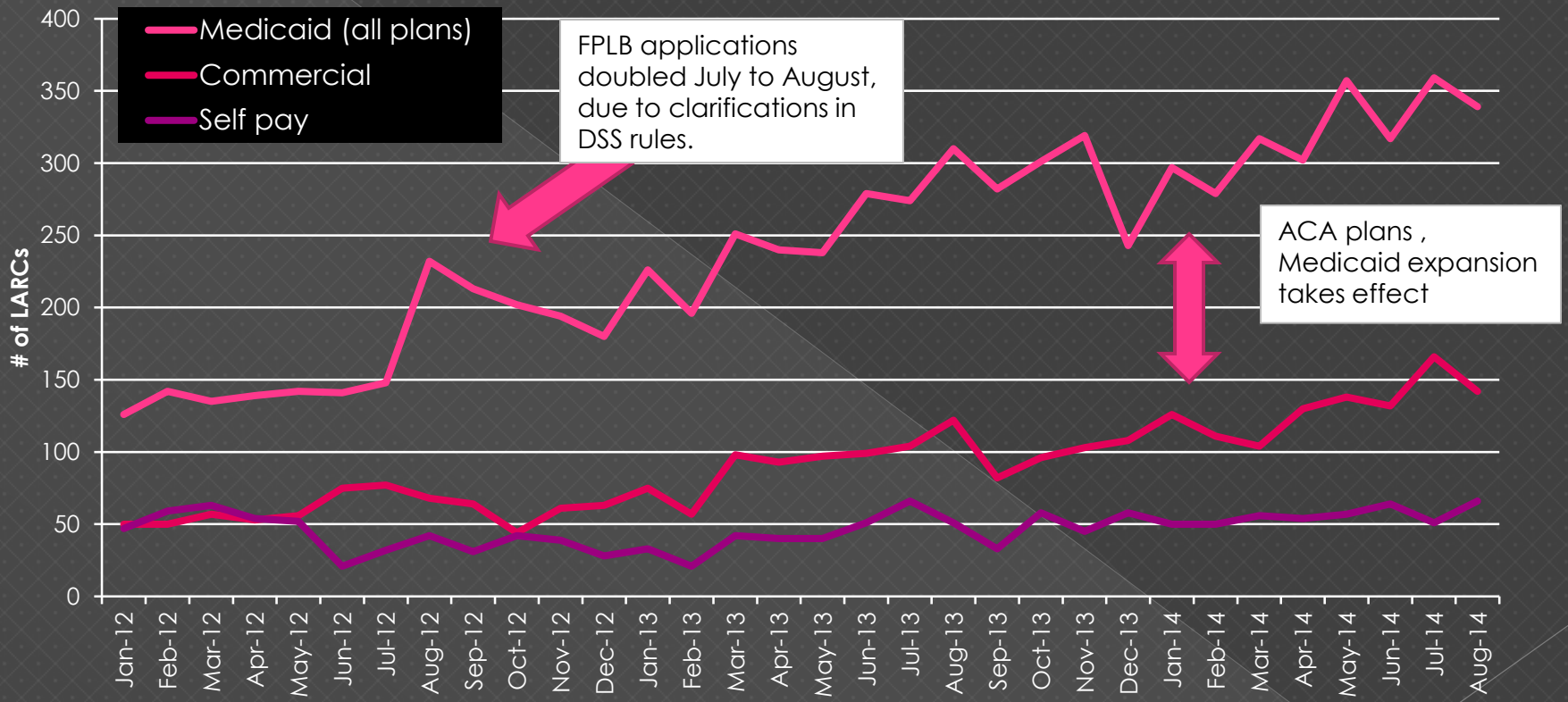
Unable to obtain data on more qualitative aspects of enrollment, i.e why MFPE eligible women chose not to enroll

Results may **not be truly reflective of the entire population of women** enrolled in MFPE -- large amount of missing data on contraceptive methods

Recommendations

Focus groups	Further investigate barriers of entry into MFPE (among Hispanic women)
Reduce disparity	Efforts to improve the adoption of highly effective methods of contraception among black women
Data Collection	More comprehensive information on patients' contraceptive use history

LARCs by payer type: PPSNE patients



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11. Kost K. Unintended Pregnancy Rates at the State Level: Estimates for 2002, 2004, 2006 and 2008. New York: Guttmacher Institute2013.

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Images

Slide 5: www.plannedparenthood.org

Slide 12: http://www.choiceproject.wustl.edu

Slide 22: www.womenshealthmag.com, www.health.com, www.cctppc.org