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Dear Colleague:

I am pleased to enclose *"State Efforts to Expand Medicaid-Funded Family Planning Show Promise,"* an examination of state initiatives to provide Medicaid-funded family planning services to individuals whose incomes are above regular Medicaid eligibility ceilings.

Reprinted from the April issue of *The Guttmacher Report on Public Policy*, this analysis is the latest in a series of special reports on public policy issues of particular relevance to the family planning field that The Alan Guttmacher Institute is preparing under a grant from the Office of Population Affairs of the Department of Health and Human Services. This piece describes the different types of Medicaid family planning expansions that are now in place in 12 states. It points out that covering additional women for family planning under Medicaid provides a badly needed source of payment for the services family planning clinics provide to lower-income women. At the same time, it highlights the benefits, in terms of contraceptive choice and health outcome, for the women served, specifically noting important data emerging from Rhode Island, where the difference between privately insured women and women on Medicaid experiencing a short interbirth interval—a well-established risk factor for low birth weight and infant mortality—has virtually disappeared since the implementation of that state's family planning expansion.

I hope you find this information useful in your work. If we can provide further information or assistance, please feel free to contact us here in the Institute's Washington Office.

Sincerely,

Cory L. Richards
Vice President for Public Policy

State Efforts to Expand Medicaid-Funded Family Planning Show Promise

In recent years, a number of states have sought and received federal permission to provide Medicaid-financed family planning services and supplies to lower income, uninsured residents whose incomes are above the state's regular Medicaid eligibility ceilings. These initiatives are beginning to show results, raising the question of whether states should be allowed to expand Medicaid eligibility for family planning on their own, as they already are allowed to do for maternity care.

By Rachel Benson Gold

Half of all public dollars for family planning services and supplies in the United States are spent through the Medicaid program. Under this critically important source of family planning support, the federal government and the states share the cost of serving eligible individuals, with the federal government contributing nine dollars for each one dollar states spend on family planning—a higher federal match than is available for other Medicaid-funded care.

While the cost of serving Medicaid enrollees is shared, it is the states that generally determine eligibility for the program—and state income-eligibility ceilings vary widely across the country. Currently averaging 46% of the federal poverty level, these ceilings range from a low of 15% of poverty in Alabama to a high of 86% in California. (The federal poverty level in 1998 was $13,650 for a family of three.)

Historically, states' income-eligibility ceilings for Medicaid were identical to those for welfare cash assistance. In fact, families were automatically enrolled in Medicaid by virtue of their qualifying for welfare (which, for adults, means being very poor *and* disabled, pregnant, elderly or in a family with dependents). Through a series of initiatives in the 1980s expanding Medicaid eligibility for maternity care, however, this historic link between Medicaid and welfare eligibility was broken; at least for maternity care, a woman's family income became the sole qualifying factor.

Eventually, Congress established a nationwide federal floor for Medicaid eligibility for pregnant women. In all states, pregnant women with incomes up to 133% of the federal poverty level became eligible for Medicaid-funded prenatal, delivery and postpartum care. States were given permission to extend eligibility to 185% of poverty at their discretion.

Under the maternity care expansions, an "expansion" woman (that is, a woman whose family income is too high to qualify her for regular Medicaid but below the ceiling for maternity care) remains eligible for care throughout her pregnancy and for 60 days postpartum, during which time family planning services may be provided. After that, the woman's coverage ceases.

Over the last several years, 12 states have built on this foundation to extend Medicaid coverage specifically for family planning beyond the 60-day postpartum period. To implement these initiatives, which have taken various forms, states have needed "permission" from the Health Care Financing Administration (HCFA). With data on these efforts starting to come in, some reproductive health advocates are beginning to wonder whether it is time to free states from the need to obtain these so-called federal waivers and give them the authority to establish these programs at their option.

State Expansions

States have taken two major avenues to expanding eligibility for Medicaid-covered family planning services and supplies (see chart). The first approach, pioneered by Rhode Island and South Carolina in 1993, built directly on the Medicaid expansions for pregnant women.

So far, eight states have obtained federal approval to continue Medicaid coverage for family planning services beyond the regular 60-day postpartum period. Generally, these programs are for about two years postpartum, although Maryland's continues coverage for five years after childbirth. (Two other states, Missouri and Washington, have applications for similar programs pending at HCFA.) Delaware varied this approach somewhat when it received approval in 1996 to continue Medicaid coverage for family planning for two years for women who were losing regular Medicaid coverage for any reason, not just following childbirth.

More recently, some states have taken an entirely different, considerably bolder approach by seeking to extend Medicaid family planning coverage services to women *who had not previously been covered under Medicaid.* Four states have received waivers to bring their income-eligibility levels for Medicaid-covered family planning services up to the eligibility levels in place for Medicaid-covered maternity care. In 1996, HCFA approved a

since it began operation in mid-1994, with approximately 1,300 enrolled at any point in time (see box). During the first year of its similar effort, Maryland provided services to nearly 5,000 women, with enrollment increasing by nearly 900 women per month during the first two years of operation.

Data are also just starting to become available from some of the newer, income-based expansions. During just the first three months of 1998, the Arkansas program, which is available to women in the state with incomes up to 133% of the poverty line, served nearly 12,000 enrollees. And in the first six months of its effort, New Mexico served nearly 5,500 women.

The state-funded program in California has enrolled nearly 780,000 individuals since it began in 1997, according to Janet Treat of the state's Office of Family Planning. Unlike many of the other efforts, the California program is open to both men and women, and approximately 5% of enrollees are men. (Under its newly approved waiver, Oregon will also provide services to men, and Washington State is developing a proposal that would include men as well.)

Because nonprofit family planning clinics likely had been providing free or partially subsidized services to many, if not most, of these previously uninsured individuals, the various state expansion programs provide an important source of payment for a clinic system struggling to provide high-quality medical care to their low-income clientele and continue to make available a broad range of contraceptive choices, including the newer, long-lasting—but more expensive—methods (see story, page 1). But, as Jeanne Atkins of the Oregon health department points out, the waiver programs have important, direct benefits for the clients as well.

Prior to the approval of Oregon's waiver, Atkins says, uninsured women with incomes above the federal poverty level were required to pay fees for their care on a sliding scale. By enrolling these women in Medicaid, under which enrollees may not be charged for the family planning services and supplies they receive, the program "will remove the financial barrier of that sliding-fee scale," with significant implications for the client. "People who had been picking up only one or two packs of pills at a time because that's all they can afford will now be able to get 13 packs at a time. That should help reduce gaps in pill use." In addition to facilitating better use of a client's current method, Atkins hopes that by eliminating patient copays while providing a source of payment for the provider, the program will put within patients' reach some of the highly effective, long-lasting methods that would have involved sizable up-front costs to the patient—or that some clinics might not have been able to make available at all.

Next Steps

The potential of these state efforts is leading some reproductive health advocates to conclude that steps should be taken to encourage other states to follow suit, or at least to allow states to do so on their own initiative.

At present, however, the only way for states to expand coverage is by obtaining a federal waiver. Increasingly, the waiver process is being seen as part of the problem, rather than part of the solution. "Obtaining a waiver can be cumbersome," says Susan Tucker of the Maryland Department of Health and Mental Hygiene, "often including months of negotiation between the state agency and HCFA. It's a process that can be both time-consuming and expensive for all the parties involved." (The New Mexico waiver, for example, was pending for nearly three years before HCFA gave final approval.) Moreover, as Tucker points out, "designing a program and preparing an application are just the first steps in a complex process." Roy Jeffis of the Arkansas Medicaid agency agrees, noting that even after approval, voluminous paperwork is still required. "These reporting requirements are a real burden to the states," says Jeffis.

Others contend that simply requiring a governor to seek "permission" from an administration that may be of another political party may be enough to chill a state's enthusiasm. Katherine Kneer of Planned Parenthood Affiliates of California says this may have been the case in her state, where former Gov. Pete Wilson, a Republican, opted to forgo seeking a federal waiver from the Clinton administration in favor of expanding coverage for family planning using exclusively state dollars. Newly elected Democratic Gov. Gray Davis, by contrast, recently announced that he intends to seek a waiver in order to access federal dollars to pay much of the cost of the program.

One answer, some advocates argue, would be for Congress to give states the authority to expand Medicaid eligibility for family planning on their own, just as they have had for 15 years for maternity care. That would help level the playing field for lower income women, these advocates say, by providing increased access to family planning to help them prevent an unintended pregnancy as well as access to prenatal and maternity services if they do become pregnant. It also, they point out, would help level the playing field for the states—which shoulder much of the cost of the reproductive choices these women make.

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waiver from Arkansas to provide family planning services to women in the state with family incomes up to 133% of poverty, far above the state's regular Medicaid eligibility level of 25%. More recently, New Mexico, Oregon and South Carolina have received approval to cover all state women with incomes up to 185% of poverty. (Kentucky has a similar application pending.)

(Of these states, South Carolina has shown particular interest in expanding its family planning coverage. In 1993, it became one of the first states to obtain federal approval to extend postpartum coverage. In 1997, it was among the first to expand coverage for all women with incomes up to 185% of poverty, far above its regular level of 18%.)

Meanwhile, building on its long-standing tradition of using *state* funds to serve individuals for whom federal funding is unavailable, California, in 1996, took the dramatic step of creating an entitlement to family planning services for both women and men whose incomes are below 200% of poverty. Unlike the other states' programs, the California effort is funded entirely with state dollars, which made federal approval unnecessary.

Outreach Efforts and Eligibility Systems

Finding and enrolling eligible individuals in need of family planning services is key to these programs' success, and, clearly, this is much easier in programs designed to serve postpartum women. These women, after all, are already in the Medicaid system and receiving Medicaid-funded care; "converting" their eligibility at the end of the 60-day postpartum period can be a relatively uncomplicated task. In Maryland, for example, the process is seamless, according to Rosemary Murphey of the Department of Health and Mental Hygiene: when a woman's postpartum eligibility is about to lapse, she says, an enrollment card for the family planning system is automatically generated and sent.

States that have adopted purely income-based eligibility standards are likely to find outreach a much more complex issue. Here, they need to locate and enroll individuals who are not currently in the system; some of these women may be resistant to participation in a program because they perceive it to be related to "welfare." This problem is similar to the ones faced by states during the maternity care expansions of the 1980s, as well as under the new State Children's Health Insurance Program (CHIP), which seeks to provide coverage to children in families with incomes well above the usual state-set Medicaid ceilings.

States have taken different approaches to meeting this challenge. New Mexico, for example, decided to incorporate outreach for the new family planning expansion into a comprehensive media campaign on health care for children and families, according to Gigette Nieto of the New Mexico Human Services Department. With the assistance of a professional marketing agency and several corporate sponsors, she reports, the state embarked on a large-scale effort that includes television, billboards and materials printed in both Spanish and English.

In contrast, state health officials in Oregon, Arkansas and California say they have relied, at least initially, largely on their current provider network to "get the word out" both to current clients who may not have a source of payment for the care they receive and, via word of mouth, to other potential enrollees as well. In addition, Oregon is designing a large-scale social marketing campaign to be rolled out in the later years of the program. To bolster its outreach efforts, Arkansas is hoping to begin to provide grants to a wide array of existing community groups.

Throughout the design and early implementation phases of its effort, California has worked to make the eligibility and enrollment process as simple as possible and one that, unlike Medicaid eligibility generally, does not require the potential enrollee to have any contact with the state social services agency. Eligibility is determined by the health care provider at the point of service. Any provider who participates in Medicaid (known in California as Medi-Cal) may be involved in the family planning program after being trained by the state. According to the state Office of Family Planning, of the nearly 2,000 providers participating in the program in early 1998, about 70% were private physicians in individual or group practices; the remainder were clinics or county health departments.

STATES WITH MEDICAID WAIVERS EXTENDING FAMILY PLANNING COVERAGE

To women who lose Medicaid coverage...		*To women solely on the basis of income*
...at the end of postpartum period	*...for any reason*	
Alabama (2 years)*	Delaware (2 years)	Arkansas (133%)
Arizona (2 years)		New Mexico (185%)
Illinois (10 months)		Oregon (185%)
Maryland (5 years)		South Carolina (185%)
New York (22 months)		
Rhode Island (2 years)		
South Carolina (22 months)		

**Mobile County only.*

To become eligible in California, a potential enrollee provides information on income, family size and whether he or she has any other available source of coverage for family planning services. Following the provider's determination of eligibility, an enrollment card is automatically activated on-site; this card may then be used to obtain services or supplies from other participating family planning providers, laboratories or pharmacies. Eligibility is certified annually.

Program Enrollment

With several of these initiatives operational for a number of years now, data are becoming available on the number of clients served. Although preliminary in many cases, these data indicate that the various state efforts have the potential to reach large numbers of enrollees.

The first programs to be up and running were those designed to extend the time postpartum family planning may be provided to women who were already enrolled in Medicaid as a result of their pregnancies, and data are available from at least two of these states. In Rhode Island, 5,400 women have participated in the program

Rhode Island: A Case in Point

As one of the earliest programs to begin operation, Rhode Island's is also one of the first efforts to generate data not only on the number of clients enrolled but on the impact of the initiative on pregnancies and births—and costs. The Rhode Island family planning effort was part of a reconfiguration of its entire Medicaid program, known as RIte Care, which expanded income eligibility levels and mandated enrollment in managed care. Birth certificate data allow the state to monitor maternal and child health indicators both before and after the implementation of RIte Care in August 1994.

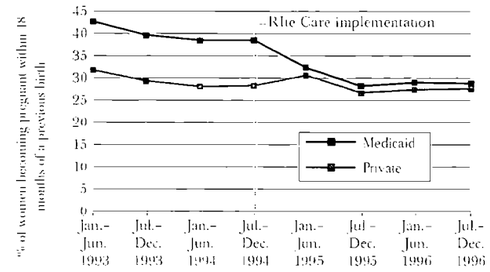
Among these indicators, according to Christine Ferguson, director of human services for the state, was the percentage of women who had private, employment-related health insurance or who received publicly subsidized care who became pregnant again shortly after having given birth. Interbirth interval is a key variable, since having a short interval between births is a well-established risk factor for low birth weight, a major cause of infant mortality in the United States.

RIte Care, including the expanded family planning program, appears to be having a dramatic impact on this important variable. In 1993, before RIte Care, 20% of women having Medicaid-funded deliveries in the state had become pregnant within nine months of a previous birth. In 1997, after RIte Care, that percentage was cut almost in half to 11%.

Even more striking, according to Ferguson, is the virtual elimination of the difference between privately insured women and Medicaid women experiencing a short interbirth interval. One year before RIte Care, 42% of women having a Medicaid-funded birth became pregnant within 18 months of a previous delivery, compared with 31% of women with private insurance coverage (see chart). Within two years, says Ferguson, the difference between the two populations "virtually collapsed. The speed with which it happened was awesome."

IMPROVED BIRTHSPACING

Difference in interbirth intervals between Medicaid enrollees and women with private insurance virtually disappeared with the implementation of RIte Care



Source: Rhode Island Department of Human Services.

Further, the RIte Care experience also demonstrates the cost-effectiveness of providing Medicaid-covered family planning services. From the program's beginning in 1994 through the end of 1997, Rhode Island spent $5.7 million on RIte Care family planning services, including the expansion program. The state estimates that this effort helped prevent 1,443 deliveries to Medicaid-eligible women during this time period.

With the state paying $5,000 per publicly funded delivery, as well as $400 per month for each newborn in the first year, prevention of these births avoided an expenditure of $14.3 million. These data, says Patricia Leddy, administrator of the RIte Care program, "clearly show that our investment in family planning services, which provided mothers in RIte Care with the ability to choose whether and when to have more children, was very cost-effective in saving more than two and one-half times our investment."

FY 2001 Policy Considerations for Abortion Provisions

	FY 2000 President's Budget	FY 2000 Enacted	Recommended FY 2001/Comment
DC	[Sec. 131. None of the funds appropriated under this Act shall be expended for any abortion except where the life of the mother would be endangered if the fetus were carried to term or where the pregnancy is the result of an act of rape or incest.][1]	Sec. 130. Retained the provision. In SAPs, we objected to the provision and offered to work with Congress. This was not considered a high priority during negotiations.	Repeat PB language (i.e. proposed deletion with the footnote: "The Administration proposes to delete this provision and will work with the Congress to address this issue."
C/J/S Justice Dept	[Sec. 103. None of the funds appropriated by this title shall be available to pay for an abortion, except where the life of the mother would be endangered if the fetus were carried to term, or in the case of rape: Provided, That should this prohibition be declared unconstitutional by a court of competent jurisdiction, this section shall be null and void.][1]	Sec. 103. Retained the provision. In SAPs, we objected to the provision and offered to work with Congress. This was not considered a high priority during negotiations.	Repeat PB language (i.e. proposed deletion with the footnote: "The Administration proposes to delete this provision and will work with the Congress to address this issue."
C/J/S Justice Dept.	Sec. [104] 103. None of the funds appropriated under this title shall be used to require any person to perform, or facilitate in any way the performance of any abortion.	Sec. 104. Same as FY 1999 enacted.	Repeat FY 2000 PB, the same as enacted.
C/J/S	Sec. [105] 104. Nothing in the preceding section shall remove the obligation of the Director of the Bureau of Prisons to provide escort services necessary for a female inmate to receive such service outside the Federal facility: Provided, That nothing in this section in any way diminishes the effect of section [104] *103* intended to address the philosophical beliefs of individuals employees of the Bureau of Prisons.	Sec. 105. Same as FY 1999 enacted.	Repeat FY 2000 PB, the same as enacted.
L/HHS/ Ed **Hyde Amendt**	[Sec. 508. (a) None of the funds appropriated under this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, shall be expended for any abortion. (b) None of the funds appropriated under this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, shall be expended for health benefits coverage that includes coverage of abortion. (c) The term "health benefits coverage" means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.][1]	Sec. 508. Retained the provision. In the SAPs, we objected to the provision and offered to work with Congress. In addition, this was not considered a high priority during negotiations.	Repeat FY 2000 PB language (i.e. propose deletion and add footnote: "The Administration proposes to delete this provision and will work with Congress to address this issue."

L/HHS/ Ed **Hyde Amend-ment**	[Sec. 509. (a) The limitations established in the preceding section shall not apply to an abortion-(1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. (b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds). (c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).][1]	Sec. 509. Retained the provision. In the SAPs, we objected to the provision and offered to work with Congress. In addition, this was not considered a high priority during negotiations.	Repeat FY 2000 PB language (i.e. propose deletion and add footnote: "The Administration proposes to delete this provision and will work with Congress to address this issue."
L/HHS/ Ed **Medi-care+ Choice**	Sec. [216] 210. None of the funds appropriated by this Act (including funds appropriated to any trust fund) may be used to carry out the Medicare+Choice program if the Secretary denies participation in such program to an otherwise eligible entity (including a Provider Sponsored Organization) because the entity informs the Secretary that it will not provide, pay for, provide coverage of, or provide referrals for abortions: Provided, That the Secretary shall make appropriate prospective adjustments to the capitation payment to such an entity (based on an actuarially sound estimate of the expected costs of providing the service to such entity's enrollees): Provided further, That nothing in this section shall be construed to change the Medicare program's coverage for such services and a Medicare+Choice organization described in this section shall be responsible for informing enrollees where to obtain information about all Medicare covered services.	Sec. 211. Same as FY 1999 enacted.	Repeat FY 2000 PB language. Same as enacted.

Foreign Ops	Sec. [518] 516. None of the funds made available to carry out part I of the Foreign Assistance Act of 1961, as amended, may be used to pay for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions. None of the funds made available to carry out part I of the Foreign Assistance Act of 1961, as amended, may be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations. None of the funds made available to carry out part I of the Foreign Assistance Act of 1961, as amended, may be used to pay for any biomedical research which relates in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning. None of the funds made available to carry out part I of the Foreign Assistance Act of 1961, as amended, may be obligated or expended for any country or organization if the President certifies that the use of these funds by any such country or organization would violate any of the above provisions related to abortions and involuntary sterilizations: Provided, That none of the funds made available under this Act may be used to lobby for or against abortion.	Sec. 518. Same as FY 1999 enacted.	Repeat FY 2000 PB language. Same as enacted.

Foreign Ops	New Provision.	Contributions to United Nations Population Fund Sec. 599C. (1) Limitations on Amount of Contribution.–Of the amounts made available under " International Organizations and Programs", not more than $25,000,000 for fiscal year 2000 shall be available for the United Nations Population Fund (hereafter in this subsection referred to as the " UNFPA"). (2) Prohibition on Use of Funds In China.-- None of the funds made available under " International Organizations and Programs" may be made available for the UNFPA for a country program in the People's Republic of China. (3) Conditions of Availability of Funds. -- Amounts made available under "International Organizations and Programs" for fiscal year 2000 for the UNFPA may not be made available for UNFPA unless – (A) the UNFPA maintains amounts made available to the UNFPA under this section in an account separate from other accounts of the UNFPA; (B) the UNFPA does not commingle amounts made available to the INFPA under this section with other sums; and (4) Report to the Congress and Withholding of Funds.__ (A) Not later than February 15, 2000, the Secretary of State shall submit a report to the appropriate congressional committees indicating the amount of funds that the United National Population Fund is budgeting for the year in which the report is submitted for country program in the People's Republic of China. (B) If a report under subparagraph (A) indicates that the United Nations Population Fund plans to spend	Delete Provision.

Foreign Ops	[Sec. 580. (a) Not to exceed $385,000,000 of the funds appropriated in title II of this Act may be available for population planning activities or other population assistance.] [(b) Such funds may be apportioned only on a monthly basis, and such monthly apportionments may not exceed 8.34 percent of the total available for such activities.]	Authorization for Population Planning Sec. 599D. (a) Authorization.–Not to exceed $385,000,000 of the funds appropriated in title II of this Act may be available for population planning activities or other population assistance. (b) Restriction on Assistance to Foreign Organizations that Perform or Actively Promote Abortions.-- (1) Performance of Abotions . . . (2) Lobbying Activities.-- . . . (3) Application for Foreign Organizations.-- . . .(c) Waiver Authority.–. . .	Delete Provision.

Foreign Ops	Sec. 543. (a) Assistance Through Nongovernmental Organizations. --Restrictions contained in this or any other Act with respect to assistance for a country shall not be construed to restrict assistance in support of programs of nongovernmental organizations from funds appropriated by this Act to carry out the provisions of chapters 1, 10,and 11 of part I and chapter 4 of part II of the Foreign Assistance Act of 1961, and from funds appropriated under the heading ``Assistance for Eastern Europe and the Baltic States'': *Provided, That the President shall take into* consideration, in any case in which a restriction on assistance would be applicable but for this subsection, whether assistance in support of programs of nongovernmental organizations is in the national interest of the United States: Provided further, That before using the authority of this subsection to furnish assistance in support of programs of nongovernmental organizations, the President shall notify the Committees on Appropriations under the regular notification procedures of those committees, including a description of the program to be assisted, the assistance to be provided, and the reasons for furnishing such assistance: Provided further, That nothing in this subsection shall be construed to alter any existing statutory prohibitions against abortion or involuntary sterilizations contained in this or any other Act. (b) Public Law 480 . . .	Sec. 541. Same as FY 1999 Enacted.	Repeat FY 2000 PB language. Same as enacted.

Foreign Ops **Title II– Bilateral Econ-omic Assis-tance** **Development Assist-ance**	For necessary expenses to carry out. . . Provided further, That none of the funds made available in this Act nor any unobligated balances from prior appropriations may be made available to any organization or program which, as determined by the President of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization: Provided further, That none of the funds made available under this heading may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions; and that in order to reduce reliance on abortion in developing nations, funds shall be available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services, and that any such voluntary family planning project shall meet the following requirements: (1) service providers or referral agents in the project shall not implement or be subject to quotas, or other numerical targets, of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning (this provision shall not be construed to include the use of quantitative estimates or indicators for budgeting and planning purposes), (2) the project shall not include payment of incentives, bribes, gratuities, or financial reward to (A) an individual in exchange for becoming a family planning acceptor, or (B) program personnel for achieving a numerical target or quota of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning services, (3) the project shall not deny any right or benefit, including the right of access to participate in any program of general welfare or the right of access to health care, as a consequence of any individual's decision not to accept family planning services,	Same as FY 1999 Enacted.	Repeat FY 2000 PB language. Same as enacted.

Foreign Ops **Cont'd**	(4) the project shall provide family planning acceptors comprehensible information on the health benefits and risks of the method chosen, including those conditions that might render the use of the method inadvisable and those adverse side effects known to be consequent to the use of the method, (5) the project shall ensure that experimental contraceptive drugs and devices and medical procedures are provided only in the context of a scientific study in which participants are advised of potential risks and benefits; and, not less than 60 days after the date on which the Administrator of the United States Agency for International Development determines that there has been a violation of the requirements contained in paragraph (1), (2), (3), or (5) of this proviso, or a pattern or practice of violations of the requirements contained in paragraph (4) of this proviso, the Administrator shall submit to the Committee on International Relations and the Committee on Appropriations of the House of Representatives and to the Committee on Foreign Relations and the Committee on Appropriations of the Senate, a report containing a description of such violation and the corrective action taken by the Agency: Provided further, That in awarding grants for natural family planning under section 104 of the Foreign Assistance Act of 1961 no applicant shall be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning; and, additionally, all such applicants shall comply with the requirements of the previous proviso: Provided further, That for purposes of this or any other Act authorizing or appropriating funds for foreign operations, export financing, and related programs, the term``motivate", as it relates to family planning assistance, shall not be construed to prohibit the provision, consistent with local law, of information or counseling about all pregnancy options: Provided further, That nothing in this paragraph shall be construed to alter any existing statutory prohibitions against abortion under section 104 of the Foreign Assistance Act of 1961: Provided further, . . .		
Foreign Ops (Cont'd)			

Foreign Ops **Peace Corps**	For expenses necessary to carry out the provisions of the Peace Corps Act (75 Stat. 612), [$240,000,000] $270,000,000, including the purchase of not to exceed five passenger motor vehicles for administrative purposes for use outside of the United States, Provided, That [none of the funds appropriated under this heading shall be used to pay for abortions: Provided further, That][1] funds appropriated under this heading shall remain available until September 30, [2000] 2001.	Retained abortion language. In the SAPs, we objected to the provision and offered to work with Congress. In addition, this was not considered a high priority during negotiations.	Repeat PB language (i.e. proposed deletion with the footnote: "The Administration proposes to delete this provision and will work with the Congress to address this issue."
Trea-su ry/ General Govern-ment **FEHB Prohibit ion**	[Sec. 509. No funds appropriated by this Act shall be available to pay for an abortion, or the administrative expenses in connection with any health plan under the Federal employees health benefit program which provides any benefits or coverage for abortions.][1]	Sec. 509. Retained the provision. In the SAPs, we strongly objected to the provision. This was not considered a high priority during negotiations.	Repeat PB language (i.e. proposed deletion with the footnote: "The Administration proposes to delete this provision and will work with the Congress to address this issue."
Trea-su ry/ General Govern-ment **FEHB Prohi-bi tion**	[Sec. 510. The provision of section 509 shall not apply where the life of the mother would be endangered if the fetus were carried to term, or the pregnancy is the result of an act of rape or incest.][1]	Sec. 510. Retained the provision. In the SAPs, we strongly objected to the provision. This was not considered a high priority during negotiations.	Repeat PB language (i.e. proposed deletion with the footnote: "The Administration proposes to delete this provision and will work with the Congress to address this issue."

Trea-sury/ Gen-eral Govern-ment as amend-ed by C/J/S	Sec. [656] 625. (a) None of the funds appropriated by this Act may be used to enter into or renew a contract which includes a provision providing prescription drug coverage, except where the contract also includes a provision for contraceptive coverage. (b) Nothing in this section shall apply to a contract with: (1) any of the following religious plans: (A) [SelectCare] Providence Health Plan; (B) [Personal CaresHMO] Personal Care's HMO; (C) Care Choices; (D) OSF Health Plans, Inc.; (E) Yellowstone Community Health Plan; and (2) any existing or future plan, if the plan objects to such coverage on the basis of religious beliefs. (c) In implementing this section, any plan that enters into or renews a contract under this section may not subject any individual to discrimination on the basis that the individual refuses to prescribe contraceptives because such activities would be contrary to the individual's religious beliefs or moral convictions. (d) Nothing in this section shall be construed to require coverage of abortion or abortion-related services.	Sec. 6 35 as amended by section 625 of the C/J/S bill (as proposed by Rep. Smith R-NJ). Section 625. Effective as of October 1, 1999, section 635 of Public Law 106-58 is amended - - (1) in subsection (b)(2), by inserting " the carrier for" after "if"; and (2) in subsection (c), by inserting " or otherwise provided for" after "to prescribe." The President's veto message on G.R. 2670 (10/26/99), and earlier version of the C/J/S bill, states that " this action violates jurisdictional concerns and is an unacceptable policy." The President's Omnibus signing statement also states, "I regret that a provision is included that would amend the recently enacted Treasury and General Government Appropriations Act, 2000, that could limit the access of Federal government employees to contraceptive coverage."	Two of the five religious plans have dropped out the the FEHBP (Providence Health Plan and Yellowstone Community Health Plan). Propose to repeat FY 2000 PB for subsection (c).

	FY 2000 President's Budget	FY 2000 Enacted	HD Recommended FY 2001/ Comment
Appro-pri ation of funds for entities under title X of the PHS Act	Sec. [211] 208. None of the funds appropriated in this Act may be made available to any entity under title X of the Public Health Service Act unless the applicant for the award certifies to the Secretary that it encourages family participation in the decision of minors to seek family planning services and that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities	Sec. 209. Same as FY 2000 PB.	**Repeat FY 2000 PB.** The same as enacted. This language does not mandate parental consent or notification and, therefore, does not need to be deleted.

Organ Procure-ment and Trans-por tation Network	Proposed to delete FY 1999 enacted language and insert: Section *209. (a)(1) in fiscal year 2000 and thereafter, the Organ Procurement and Transplantation Network ("OPTN") shall provide to the Secretary, upon request, any data necessary to assess the effectiveness of the Nation's organ donation, procurement and organ allocation systems, or to assess the quality of care provided to all transplant patients, and analysis of such data in a scientifically and clinically valid manner. If necessary, the OPTN may provide additional data as they deem appropriate. (2) The OPTN shall make available to the public timely and accurate program-specific information on the performance of transplant programs. These data shall be updated as frequently as possible, and the OPTN shall work to shorten the time period for data collection and analysis in producing its center-specific outcomes report, including severity adjusted long term survival rates. Such data shall also include such other cost or performance information including but not limited to transplant program-specific information on waiting time within medical status, organ waitings, and refusal or organ offers. (b) Data provided under section (a) shall be specific (if possible) to individual transplant centers and must be determined in a scientifically and clinically valid manner. (c) Any disclosure of patient specific medical information under subsection (a) shall be subject to the restrictions contained in the Freedom of Information Act, the Privacy Act, and State laws. (d) For purposes of this section:*	Sec. 210. The final rule entitled "Organ Procurement and Transplantation Network", promulgated by the Secretary of Health and Human Services on April 2, 1998 (63 Fed. Reg. 16295 et seq.) (relating to part 121 of title 42, Code of Federal Regulations), together with the amendments to such rules promulgated on October 20, 1999 (64 Fed. Reg. 56649 et seq.) shall not become effective before the expiration of the 42 day period beginning on the date of the enactment of this Act. **H.R. 1180**– Section 413. Delay of Effective Date of Organ Procurement and Transplantation Network Final Rule. (a) In General.–The final rule entitled "Organ Procurement and Transplantation Network", promulgated by the Secretary of Health and Human Services on April 2, 1998 (63 Fed. Reg. 16295 et seq.) (relating to part 121 of title 42, Code of Federal Regulations), together with the amendments to such rules promulgated on October 20, 1999 (64 Fed. Reg. 56649 et seq.) shall not become effective before the expiration of the 90-day period beginning on the date of the enactment of this Act. (b) Notice and Review.–For purposed of subsection (a): (1) Not later than 3 days after the date of the enactment of this Act, the Secretary of Health and Human Services (referred to int his subsection as the "Secretary") shall publish in the	**Propose to delete.**

Organs (cont.)	*(1) The term "Organ Procurement and Transportation Network" means the network operated under section 372 of the Public Health Service Act. (2) The term "Secretary" means the Secretary of Health and Human Services.*	Federal Register a notice providing that the period within which comments on the final rule may be submitted to the Secretary is 60 days after the date of such publication of the notice. (2) Not later than 21 days after the expiration of such 60-day period, the Secretary shall complete the review of the comments submitted pursuant to paragraph (1) and shall amend the final rule with any revisions appropriate according to the review by the Secretary of such comments. The final rule may be in the form of amendments to the rule referred to in subsection (a) that was promulgated on April 2, 1998, and in the form of amendments to the rule referred to in such subsection that was promulgated on October 20, 1999.	

Medicare + Choice abortion language	Sec. [216] 210. None of the funds appropriated by this Act (including funds appropriated to any trust fund) may be used to carry out the Medicare+Choice program if the Secretary denies participation in such program to an otherwise eligible entity (including a Provider Sponsored Organization) because the entity informs the Secretary that it will not provide, pay for, provide coverage of, or provide referrals for abortions: Provided, That the Secretary shall make appropriate prospective adjustments to the capitation payment to such an entity (based on an actuarially sound estimate of the expected costs of providing the service to such entity's enrollees): Provided further, That nothing in this section shall be construed to change the Medicare program's coverage for such services and a Medicare+Choice organization described in this section shall be responsible for informing enrollees where to obtain information about all Medicare covered services.	Sec. 211. Same.	**Repeat FY 2000 PB language.** Same as FY 2000 enacted.
Medicare Compe-tit ive Pricing Demo Project	New in FY 2000 enacted.	Sec. 215. None of the funds provided in this Act or in any other Act making appropriations for fiscal year 2000 may be used to administer or implement in Arizona or in the Kansas City, Missouri or in the Kansas City, Kansas area the Medicare Competitive Pricing Demonstration Project (operated by the Secretary of Health and Human Services under authority granted in section 4011 of the Balanced Budget Act of 1997 (Public Law 105-33)).	**Propose to delete**– we opposed this language in SAPs. This demonstration will provide valuable information that eventually will help allow HCFA to implement the Competitive Defined Benefit program proposed in the President's Medicare reform plan.

With-holding of Substance Abuse Funds (Synar Amndmt)	New in FY 2000 enacted.	Sec. 218. WITHHOLDING OF SUBSTANCE ABUSE FUNDS. (a) IN GENERAL. –None of the funds appropriated by this Act may be used to withhold substance abuse funding from a State pursuant to section 1926 of the Public Health Service Act (42 U.S.C. 3000x-26) if such State certifies to the Secretary of Health and Human Services that the State will commit additional State funds, in accordance with subsection (b), to ensure compliance with State laws prohibiting the sale of tobacco products to individuals under 18 years of age. (b) AMOUNT OF STATE FUNDS.–The amount of funds to be committed by a State under subsection (a) shall be equal to 1 percent of such State's substance abuse block grant allocation for each percentage point by which the State misses the retailer compliance rate goal established by the Secretary of Health and Human Services under section 1926 of such Act, except that the Secretary may agree to a smaller commitment of additional funds by the State. (c) SUPPLEMENT NOT SUPPLANT.–Amounts expended by a State pursuant to a certification under subsection (a) shall be used to supplement and not supplant State funds used for tobacco prevention programs and for compliance activities described in such subsection in the fiscal year preceding the fiscal year to which this section applies.	**Proposed deletion** with the footnote: "The Administration proposes to delete this provision and will work with the Congress to address this issue." This provision was a one time solution to HHS' problem of having to assess 40% penalties on a number of states' Substance Abuse Block Brant funds because they missed their youth smoking reduction targets. Deleting this section may concern some whose goal is to avoid the assessment of such a penalty. However, this provision was supported by the Administration in the context of a one-year solution only, and with the commitment to work on a permanent legislative change to the Synar penalty structure. Not deleting this section could be a signal that the Administration no longer supports a more permanent change– which it *does*. SAMHSA, DPC and ASL have discussed building the structure of and legislative support for a permanent change to prevent this one-time fix from becoming an annual solution in the appropriations process.
(Synar amndmt cont..)		(d) ENFORCEMENT OF STATE EXPENDITURE.-- The Secretary shall exercise discretion in enforcing the timing of the State expenditure requiring by the certification described in subsection (a) as late as July 31, 2000.	

Coverage of injectable drugs	New in FY 2000 enacted.	Sec. 219. None of the funds made available under this title may be used to carry out the transmittal of August 13, 1997 (relating to self-administered drugs) of the Deputy Director of the Division of Acute Care of the Health Care Financing Administration to regional offices of such Administration or to promulgate any regulation or other transmittal or policy directive that has the effect of imposing (or clarifying the imposition of) a restriction on the coverage of injectable drugs under section 1861(s)(2) of the Social Security Act beyond the restrictions applied before the date of such transmittal.	**Propose to delete.**

Needle Exchange **DC Bill** Needle Exchange language	Sec. 505. Notwithstanding any other provision of this Act, no funds appropriated under this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug *unless the Secretary of Health and Human Services determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs.* **DC Bill** [Section 170. None of the funds contained in this Act may be used for any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug, or for any payment to any individual or entity who carries out any such program.]	Sec. 505. Repeated FY 99 language, which did not include the exception in the FY 2000 President's Budget. **D.C. Appropriations Bill language for Needles**: Sec. 150. (a) None of the funds contained in the Act may be used for any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug. (b) Any individual or entity who receives any funds contained in this Act and who carries out any program described in subsection (a) shall account for all funds used for such programs separately from any funds contained in this Act.	L/HHS language: Repeat FY 2000 President's Budget. **DC language options**: Repeat FY 2000 President's Budget.
Appro-pri ations limitation s for abortion procedure (Hyde language)	[Sec. 508. (a) None of the funds appropriated under this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, shall be expended for any abortion. (b) None of the funds appropriated under this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, shall be expended for health benefits coverage that includes coverage of abortion .c) The term ``health benefits coverage'' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.]1	Sec. 508. Retained the provision and added." In the SAPs, we objected to the provision and offered to work with the Congress, but did not specifically mention the trust fund language. In addition, this was not considered a high priority item during negotiations.	**Repeat FY 2000 PB language** (i.e., proposed deletion with the footnote: " The Administration proposes to delete this provision and will work with the Congress to address this issue."

Appro-pri ations limitation s for abortion procedure (Hyde language)	[Sec. 509. (a) The limitations established in the preceding section shall not apply to an abortion--(1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds). (c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).]1	Sec. 509. Same as FY 99 enacted. In the SAPs, we objected to the provision and offered to work with the Congress, but did not specifically mention the trust fund language. In addition, this was not considered a high priority item during negotiations.	**Repeat FY 2000 PB language** (i.e., propose deletion and add footnote: " The Administration proposes to delete this provision and will work with the Congress to address this issue.")

Use of funds for embryo research-limitations	Sec. [511] 509. (a) None of the funds made available in this Act may be used for-- (1) the creation of a human embryo or embryos for research purposes; or(2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.208(a)(2) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).(b) For purposes of this section, the term ``human embryo or embryos'' includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.	Sec. 510. Same as proposed in Budget and FY 1999 enacted.	This provision prohibits the use of appropriations to create or destroy human embryos for research purposes. Previous Budgets have stricken the ban, proposing instead that the ban be addressed in separate, non-appropriations legislation. During the FY 2000 appropriation negotiations, Sen. Lott promised that the Senate would consider a stand-alone bill on stem cell research in early 2000. Consideration of this bill will likely lead to **three options/outcomes**: (1) the ban on embryo research covers research on stem cells; (2) the ban on embryo research does not cover stem cells [current policy]; or (3) the ban on embryo research should be lifted entirely -- per NBAC recommendation. Research findings on the related topic of stem cell research complicate the decision on whether or not to include Section 511 in the FY 2001 Budget. The central issue is whether or not the ban on embryo research would cover stem cell research, recent findings on which have demonstrated an enormous potential for treating disease such as diabetes (Type I) and Parkinson's.

Unique Health Identifier	Sec. [516] 512. None of the funds made available in this Act may be used to promulgate or adopt any final standard under section 1173(b) of the Social Security Act (42 U.S.C. 1320d-2(b)) providing for, or providing for the assignment of, a unique health identifier for an individual (except in an individual's capacity as an employer or a health care provider), until [legislation is enacted specifically approving the standard] *comprehensive privacy protections are in place pursuant to section 264 of P.L. 104-191.*	Sec. 514. Same as FY 1999 enacted.	**Propose to delete.**