NHeLP
NATIONAL HEALTH LAW PROGRAM

Protect Medicaid Funding

Women's Health

Issue # 2

Medicaid provides a long-term investment in health that helps people succeed. It increases the diagnosis and early treatment of chronic conditions, enhances educational achievement and future earnings for covered children, and reduces health care disparities.[1] Medicaid coverage is tailored to the unique needs of low-income individuals and families, but still costs less per enrollee than employer-based insurance.[2] Despite Medicaid's proven success and efficient use of funds, opponents repeatedly seek to cut or cap funding for the program. These proposals seriously jeopardize the health and financial security of the 97 million people who benefit from Medicaid each year.[3] Medicaid's core consumer protections make the program work for enrolled populations, including children, parents, pregnant women, low-income workers, older adults, and people with disabilities. This fact sheet explains why Medicaid is so critical for women and how they would be harmed by Medicaid funding caps.

Why Medicaid is important for women's health:

- **Medicaid provides coverage to nearly 17 million non-elderly adult women.**[4] Women are significantly more likely to live in poverty than men, and therefore Medicaid is a vital source of health coverage for this population. Under Medicaid law, all states must cover certain low-income women, including pregnant women and very low-income parents. Medicaid finances almost half of all births in the United States.[5] In addition, almost all states have taken the Medicaid option to cover women in treatment for breast or cervical cancer. In the 32 states that expanded Medicaid, most previously uninsured low-income women are now covered.

- **Medicaid provides critical coverage for women needing family planning services and supplies.** Under Medicaid law, all states must cover family planning services and supplies (FPSS) without cost sharing for individuals who want to prevent pregnancy.[6] Furthermore, Medicaid includes a number of special protections to ensure that women can access FPSS: Medicaid requires states to give women "freedom of choice" to visit any Medicaid provider to obtain FPSS (including providers outside an enrollee's managed care plan), and provides states with 90% federal funding for FPSS, giving states a strong incentive to provide these services.[7] Medicaid also allows states to provide FPSS to many individuals not otherwise eligible for Medicaid. This is especially important in states that have not expanded Medicaid. As a result of these protections and incentives, Medicaid finances nearly three-quarters of all publicly funded family

planning services nationwide.[8] Publicly funded family planning is cost effective, saving over $7.00 for every dollar spent.[9]

***How funding caps would harm women*:**

- **Funding caps threaten the coverage of millions of women.** Block grants and per capita cap proposals reduce the amount of federal funding available to states to help provide essential health care services to low-income women. With less funding, states would likely scale-back eligibility for their Medicaid programs. States that expanded Medicaid might reverse course, while states considering expanding might halt their efforts. States might also lower the income eligibility for pregnant women or drop critical optional programs such as coverage for women with breast and cervical cancer, causing millions of women to lose coverage.

- **Funding caps could lead states to reduce critical services for women.** States struggling to fund their Medicaid budgets would likely reduce the services available to the women who remain eligible. For example, states could narrow the list of pregnancy-related services available to pregnant women. States could also impose limits that would harm women with special health care needs. A state might attempt to limit the amount of physical or rehabilitative therapy available to a woman with a physical injury. Lack of services could turn an injury into a permanent disability that could affect many aspects of her life. They might also limit the number of prescriptions a person can fill per month, leaving women with chronic conditions without necessary medications.

- **Funding caps would weaken access to care for women.** Under the financial pressure from funding caps, states might also seek to roll back or request exceptions to federal standards that ensure access to care for women. Federal regulators might waive the freedom of choice requirement allowing women to visit any provider of their choice for FPSS. Putting women in restrictive provider networks could "save" states money in the short-term, but the rate of unintended pregnancies would increase if women can't see their provider, thus negating any real savings. States would also be likely to shift costs onto low-income women by attempting to overturn the long-standing prohibition on cost sharing for FPSS, as well as by increasing cost sharing on all other services.

- **Funding caps might lead to weakened protections for pregnant women.** Caps on federal funding could be accompanied by weakening of important federal protections for pregnant women. For example, current law requires that states maintain pregnancy coverage for women until the end of the month in which a pregnant woman's 60-day post-partum period ends.[10] Another example is the long-standing protection requiring that infants born to mothers receiving Medicaid be automatically enrolled in Medicaid and remain eligible for a full year, unless family income increases sharply.[11]

[1] Harvey W. Kaufman et al., *Surge in Newly Identified Diabetes among Medicaid Patients in 2015 within Medicaid Expansion States under the Affordable Care Act*, 38 DIABETES CARE 833 (2015) (Medicaid coverage improves diabetes screening and treatment initiation); DAVID W. BROWN ET AL., NAT'L BUREAU OF ECON. RESEARCH, MEDICAID AS AN INVESTMENT IN CHILDREN: WHAT IS THE LONG-TERM IMPACT ON TAX RECEIPTS? 20 (2015), http://www.nber.org/papers/w20835 (Medicaid improves long-term outcomes for children); Thomas C. Buchmeuller et al., *Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage* 106 AM. J. PUB. HEALTH 1416, 1420 (2016) (Medicaid expansion reduced health care disparities).

[2] TERESA COUGHLIN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, WHAT DIFFERENCE DOES MEDICAID MAKE? 4, 7 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf (Employer-based coverage would cost 28% more than covering the same low-income individual with Medicaid).

[3] CONG. BUDGET OFFICE, DETAIL OF SPENDING AND ENROLLMENT FOR MEDICAID FOR CBO'S MARCH 2016 BASELINE (2016), https://www.cbo.gov/sites/default/files/51301-2016-03-Medicaid.pdf. Though 97 million individuals enrolled in Medicaid over the course of 2015, the average monthly enrollment was 76 million. *Id*. This underscores the importance of Medicaid as a source of coverage for individuals who temporarily lose coverage, such as individuals between jobs.

[4] This figure accounts for women ages 19-64 who are enrolled in Medicaid. KAISER FAMILY FOUNDATION, WOMEN'S HEALTH INSURANCE COVERAGE 1 (2016), http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage.

[5] Anne Rossier Markus et al., *Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform*, 23-5 WOMEN'S HEALTH ISSUES e273, e275 (2013), http://www.whijournal.com/article/S1049-3867%2813%2900055-8/pdf.

[6] 42 U.S.C. § 1396d(a)(4)(C); 42 C.F.R § 441.20.

[7] 42 U.S.C. § 1396a(a)(23)(B); 42 C.F.R. § 431.51(a)(3).

[8] ADAM SONFIELD & RACHEL BENSON GOLD, GUTTMACHER INST., PUBLIC FUNDING FOR FAMILY PLANNING, STERILIZATION AND ABORTION SERVICES, FY 1980-2010, at 8 (2012), https://www.guttmacher.org/pubs/Public-Funding-FP-2010.pdf.

[9] GUTTMACHER INSTITUTE, IN BRIEF: FACT SHEET, PUBLICLY FUNDED FAMILY PLANNING SERVICES IN THE UNITED STATES (Oct. 2014), http://www.guttmacher.org/pubs/fb_contraceptive_serv.html.

[10] 42 U.S.C. §1396a(e)(6).

[11] *Id*. § 1396a(e)(4); 42 C.F.R. § 435.117. Children born to mothers receiving Medicaid on their date of birth are automatically deemed eligible and enrolled in Medicaid as of that date, meaning there is no administrative obligation for families or delay in starting a newborn's coverage. Such children automatically remain eligible for Medicaid for a full year as long as the mother's income does not exceed the Medicaid pregnancy limit (which may be higher than normal limits).