Top Ten Threats to Women's Reproductive Health Under the Graham-Cassidy Bill

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Republican Sens. Lindsey Graham (S.C.), Bill Cassidy (La.), Dean Heller (Nev.) and Ron Johnson (Wis.) released a bill on Sept. 14 (hereinafter "Graham-Cassidy") to repeal the ACA and eliminate the current financing structure of Medicaid. This bill, extremely similar but in some ways worse than the failed Better Care Reconciliation Act (BCRA 2.0), would strip coverage from millions, strike a death blow to Medicaid as we know it, and fundamentally threaten the health and well-being of women across the country. This fact sheet demonstrates how the Graham-Cassidy bill impacts women's reproductive health access.

1. ***Slashes Medicaid Funding for Reproductive Health Services by Implementing a Per Capita Cap.*** Medicaid is a critical source of reproductive health services for low-income women, covering half of all births in the United States and three quarters of all publicly funded family planning services.[1] Since 1965, Medicaid has operated as a federal-state partnership where states receive, on average, 63% of the costs of providing Medicaid from the federal government.[2] The federal share is based on actual costs of providing services, and lower income states receive more federal funding. Graham-Cassidy limits the federal contribution to states, based on a state's historical expenditures inflated at a rate that is projected to be less than the yearly growth of Medicaid costs.[3] Beginning January 1, 2020, funding for state Medicaid programs will shrink over time, resulting in states cutting coverage and services for all enrollees. And starting in 2025, states would be limited to an even lower growth rate than in the initial PCC years. Graham-Cassidy also imposes a penalty on states that spend above the national mean, starting in 2020 (two years earlier than BCRA). This penalty would be imposed even if a state spends more because care is more costly due to geography or other factors or because enrollees are older or sicker than in another state. Overall, the end result is that federal funding for Medicaid would shrink significantly. In response, states would be forced to cut coverage and services for all Medicaid enrollees, including the 13 million women of reproductive age enrolled in Medicaid.[4] States could also reduce Medicaid eligibility, for example by lowering income eligibility levels for pregnant women in optional eligibility categories.[5] The result is that Medicaid would cover fewer women and provide less comprehensive reproductive health services to those who remain enrolled.

2. ***Reduces Access to Care for Low Income Women by Gutting and then Ending Medicaid Expansion.*** The expansion of Medicaid enacted in the ACA has provided a significant source of coverage for millions of women, and has been critical to improving both maternal and child health outcomes by providing access to comprehensive health care services, including preconception services, for women who will or who are planning to conceive.[6] Effective October 1, 2017, the Graham-Cassidy bill allows states to conduct redeterminations for Medicaid expansion populations every six months, and actually encourages states to conduct even more frequent redeterminations by offering a 5% increase in the federal match rate from October 1, 2017 through December 31 2019 for redeterminations made at least every six months. Graham-Cassidy then goes a step further than previous Senate bills by reducing the federal match rate to 0% for any state that covers Medicaid expansion enrollees after January 1, 2020 (except for Native Americans who meet certain "grandfathering" requirements). Even if a state wanted to continue covering Medicaid expansion enrollees past that point, it could not receive any federal funding and would have to pay 100% of the costs. Needless to say, expansion states are unlikely to be able to make up the difference in federal funding with state funds. Graham-Cassidy proposes to replace both Medicaid expansion and marketplace subsidies with a time-limited block grant that is set at 17% less than current funding, and which would phase out completely after 2026.

3. ***Jeopardizes the Economic Stability of Individuals and Families by Reducing Medicaid Retroactive Eligibility to Two Months for Most Enrollees.*** Medicaid has long provided coverage for up to three months before the month an individual applies for coverage. This "retroactive coverage" protects individuals from medical expenses they incurred before they apply for Medicaid. An individual may not be able to apply for Medicaid immediately due to hospitalization, a disability, or other circumstances. Retroactive coverage has thus saved millions of individuals and families from the burden of unexpected medical debt and possible financial bankruptcy. Effective October 1, 2017, Graham-Cassidy reduces retroactive coverage to two months for all Medicaid enrollees except for those 65 years or older, and those eligible for Medicaid based on blindness or disability.

4. ***Allows States to Implement Medicaid Work Requirements for Most Adult Enrollees, Including Women Who Have Recently Given Birth.*** The Graham-Cassidy bill allows states to institute a work requirement for most adult Medicaid enrollees beginning October 1, 2017. Currently, nearly 8 in 10 Medicaid enrollees are part of a working family. Another 14% of Medicaid enrollees are currently looking for work. Yet Graham-Cassidy would allow states to require work as a condition of eligibility, including enrollees who are caring for a parent or spouse, as well as both parents in a two-parent household. Further, individuals receiving mental health or substance use disorder services who are eligible through Medicaid expansion (rather than a disability category) would also be required to work as a condition of receiving treatment, which could undermine their progress and recovery. In addition to running counter to the very purpose of Medicaid, work requirements have also proven ineffective in either decreasing poverty or increasing employment.[7] The only enrollees exempt from the work requirement are children, older adults, people with disabilities, pregnant women

through the postpartum period, certain single parents and caretakers, participants in some drug and alcohol treatment programs, and certain categories of students. Notably, while pregnant women are exempt, a woman who has recently given birth would still be required to fulfill the work requirement immediately after a postpartum period which could be as short as eight to nine weeks, a fact which contradicts what we know about postpartum recovery and the importance of newborn bonding.[8]

5. ***Prevents Women on Medicaid from Obtaining Services at Planned Parenthood.*** The Graham-Cassidy bill resurrects the previous ACA repeal bills' provisions targeting Planned Parenthood by prohibiting the organization from participating in the Medicaid program for one year, starting on the date of the bill's enactment. This would mean many Medicaid enrollees would no longer be able to receive Medicaid-covered services from their trusted provider of choice. Excluding Planned Parenthood from the Medicaid program reduces access to essential preventive care, such as contraception, tests and treatment for sexually transmitted infections, and breast and cervical cancer screenings. Other safety-net providers such as community health centers lack the capacity to serve all the Medicaid enrollees who could no longer receive care at Planned Parenthood. As a result, in some areas of the country, particularly rural areas, people would lose access to critical reproductive health services.

6. ***Allows States to Slash Medicaid Funding for Reproductive Health Services by Operating Medicaid as a Block Grant for Certain Populations*.** Graham-Cassidy gives states the option to operate their Medicaid program as a block grant for people who are not elderly, disabled, or pregnant. States would be locked in to the block grant option for a five-year period, and the growth rate would be lower than the initial per capita cap growth rate (although by 2025, both the per capita cap and block grant growth rates would be the same). Federal funding for Medicaid under a block grant structure would fail to meet the demand and shrink over time, both because of the lower growth rate and because a block grant does not increase with enrollment. The result is states would cut coverage and services for all enrollees, including women who rely on Medicaid for access to reproductive health services.

7. ***Makes Private Coverage for Women Less Affordable.*** Nearly 7 million women and girls selected a private insurance marketplace plan during the 2016 open enrollment period.[9] The majority relied on the ACA's federal subsidies to help make the coverage more affordable. Graham-Cassidy bill eliminates the ACA's current income-based premium tax credits and cost-sharing reductions effective January 1, 2020. The bill then proposes to replace both Medicaid expansion and marketplace subsidies with a time-limited block grant that is set at 17% less than current funding, and which would phase out completely after 2026.[10] Taken together, these changes would raise premiums, increase deductibles, and make it harder for women and girls to afford high-quality comprehensive health care that meets their needs.

8. ***Restricts Access to Abortion Care in Private Plans.*** The Graham-Cassidy bill includes restrictions that prohibit individuals and small employers, effective January 1, 2018, from using federal tax credits to purchase private health insurance plans that

include abortion coverage beyond the Hyde exceptions.[11] The bill also specifically prohibits individuals from using their Health Savings Accounts to pay for a High Deductible Health Plan that covers abortion beyond the Hyde exceptions, also effective January 1, 2018. These provisions could cause insurance companies to stop offering plans that include abortion coverage altogether, thereby putting abortion access further out of reach for women in the private market. The provisions are also of particular concern for states that broadly require abortion coverage in all or most of their private plans, such as California and New York, since the restriction either forces these states to change their policies on abortion coverage, or run the risk of dramatically reducing the number of state residents who are eligible for federal tax credits.

9. ***Allows States to Waive Essential Health Benefits Requirements Which Guarantee Coverage for Maternity and Newborn Care.*** The ACA requires that all plans in the individual and small group markets include ten specified essential health benefits (EHBs), which include maternity and newborn care, as well as other services essential to basic reproductive health such as preventive and wellness services, mental health and substance use disorder services, and prescription drugs. Graham-Cassidy makes it easier for states to waive the EHB requirement. One study found that if a state eliminated the EHB requirement to cover maternity care, the premium for a maternity care rider would cost a woman an additional $17,320 in 2026.[12] Prior to passage of the ACA, only 12% of individual health plans across the country covered maternity care, resulting in high out-of-pocket costs for pregnant women.[13] Elimination of the EHB requirement would again leave many women without adequate maternity care or force them to incur debt to obtain care. It would also effectively allow plans to practice gender discrimination by requiring women to pay more for plans that do include maternity care.

10. ***Allows States to Weaken Protection for People with Pre-Existing Conditions.*** Prior to passage of the ACA, insurers regularly charged women higher premiums, or outright denied them coverage, based on preexisting condition exclusions such as being cancer survivors, having had a cesarean section, having received medical treatment from domestic violence or sexual assault, or for being pregnant.[14] The ACA changed this by prohibiting health plans from either denying coverage or charging higher premiums to people with pre-existing conditions. In addition to the issues specifically related to maternity and newborn care above, health plans in states that choose to modify or eliminate EHBs would likely offer less comprehensive plans that lack the specific services people with pre-existing conditions need. People with pre-existing conditions would be forced to pay higher premiums for more comprehensive coverage that includes their needed services. The result would be an end run around the ACA's prohibition on discriminating against people with pre-existing conditions. Elimination of this ACA protection could prevent women with chronic and other pre-existing conditions from obtaining health insurance that meets their needs, or indeed from obtaining health insurance at all.

ENDNOTES

[1] 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; ADAM SONFIELD & RACHEL BENSON GOLD, GUTTMACHER INSTITUTE, 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.

[2] KAISER FAMILY FOUNDATION, FEDERAL AND STATE SHARE OF MEDICAID SPENDING (Jan. 2017), http://kff.org/medicaid/state-indicator/federalstate-share-of-spending.

[3] Graham-Cassidy's growth rate from the state's base year through 2019 is the medical component of the Consumer Price Index (CPI-M). For 2019-2025, the growth rate would be CPI-M plus 1% for elderly enrollees and enrollees with disabilities and CPI-M for adults and children. Beginning in 2025, the growth rate would lower to the "regular" CPI which grows even slower than CPI-M and does not include long term care costs.

[4] GUTTMACHER INSTITUTE, UNINSURED RATE AMONG WOMEN OF REPRODUCTIVE AGE HAS FALLEN MORE THAN ONE-THIRD UNDER THE AFFORDABLE CARE ACT (Nov. 2016), https://www.guttmacher.org/article/2016/11/uninsured-rate-among-women-reproductive-age-has-fallen-more-one-third-under.

[5] States are required to cover pregnant women up to at least 133 percent of the poverty level, and in some states the upper limit is even higher. However, many states have voluntarily set eligibility limits for pregnant women at much higher levels. For a chart of the current state income limits for Medicaid coverage for pregnant women, alongside the minimum income eligibility level below which the state cannot drop, see AMY CHEN & MARISA SPALDING, NATIONAL HEALTH LAW PROGRAM, STATE CREATION OF SPECIAL ENROLLMENT PERIODS FOR PREGNANCY at Appendix A (Jan. 2017), http://www.healthlaw.org/issues/reproductive-health/pregnancy/state-creation-of-sep-for-pregnancy.

[6] *See* AMY CHEN & DAPHNE WILSON, NATIONAL HEALTH LAW PROGRAM, HOW MEDICAID EXPANSION BENEFITS MATERNAL AND CHILD HEALTH (Apr. 2017), http://www.healthlaw.org/publications/browse-all-publications/how-medicaid-expansion-benefits-maternal-and-child-health.

[7] LADONNA PAVETTI, CENTER ON BUDGET AND POLICY PRIORITIES, WORK REQUIREMENTS DON'T CUT POVERTY, EVIDENCE SHOWS (Jun. 2016), http://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows. For more on Medicaid work requirements, see JANE PERKINS ET AL., NATIONAL HEALTH LAW PROGRAM, MEDICAID WORK REQUIREMENTS - NOT A HEALTHY CHOICE (Mar. 2017), http://www.healthlaw.org/publications/browse-all-publications/medicaid-work-requirements-not-a-healthy-choice; JANE PERKINS, NATIONAL HEALTH LAW PROGRAM, MEDICAID WORK REQUIREMENTS - LEGALLY SUSPECT (Mar. 2017), http://www.healthlaw.org/publications/browse-all-publications/medicaid-work-requirements-legally-suspect.

[8] The postpartum period extends through the last day of the month in which the 60th day following the end of the pregnancy occurs.

[9] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, HEALTH INSURANCE MARKETPLACES 2016 OPEN ENROLLMENT PERIOD: FINAL ENROLLMENT REPORT (March 2016) https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf.

[10] CENTER ON BUDGET AND POLICY PRIORITIES, LIKE OTHER ACA REPEAL BILLS, CASSIDY-GRAHAM PLAN WOULD ADD MILLIONS TO UNINSURED, DESTABILIZE INDIVIDUAL MARKET (Sep. 2017), https://www.cbpp.org/research/health/like-other-aca-repeal-bills-cassidy-graham-plan-would-add-millions-to-uninsured.

[11] The Hyde exceptions are abortions that are necessary to save the life of the mother, or to terminate pregnancies that are the result of rape or incest.

[12] SAM BERGER & EMILY GEE, CENTER FOR AMERICAN PROGRESS, SENATE HEALTH CARE BILL COULD DRIVE UP COVERAGE COSTS FOR MATERNITY CARE AND MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT (Jun. 2017), https://www.americanprogress.org/issues/healthcare/news/2017/06/20/434670/senate-health-care-bill-drive-coverage-costs-maternity-care-mental-health-substance-use-disorder-treatment.

[13] NATIONAL WOMEN'S LAW CENTER, WOMEN AND THE HEALTH CARE LAW IN THE UNITED STATES (May 2013), https://nwlc.org/wp-content/uploads/2015/08/us_healthstateprofiles.pdf.

[14] *Id*.