The Importance of Medicaid as an Entitlement Program to Address Reproductive Health Disparities

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Date: January 28, 2013

Introduction

Women of reproductive age experience a variety of health disparities and heavily rely on Medicaid to prevent unintended pregnancies and receive screenings and treatments for breast and cervical cancer, sexually transmitted infections (STIs), and HIV/AIDS. Medicaid coverage is also critical to healthier pregnancies and improved birth outcomes.

The structure of Medicaid as an "entitlement" program is essential to its ability to provide reproductive health services to low-income women and women of color. The federal entitlement gives all eligible individuals a legal right to enroll and access health coverage, services, and benefits.[1] Funding is not capped for these services and can be adjusted to meet increased demand during times of economic recession.

A number of Congressional proposals in recent years have sought to transform Medicaid from an entitlement program into a more limited program. The proposals generally offer states a fixed amount of money that would result in restricted enrollment and services. Low-income women residing in poorer states would suffer greater harm because states would resort to cutting their Medicaid programs to avoid overspending their allotted federal funding.

Continuous insurance coverage helps to ensure that women of color and other low-income women have access to reproductive health and primary care services to prevent and address health disparities. Women of color disproportionately have less income and are likely to experience significant gaps in health access, quality of care and health outcomes. Proposals that dismantle the current entitlement structure of Medicaid will only curtail the availability of coverage for health services in these communities.

This issue brief includes a discussion of various legislative proposals that would negatively impact the program's enrollees, particularly low-income women and women of color, and an appendix with an overview of the current Medicaid program. Although the current structure of the Medicaid program remains intact for the moment, it is important to be aware of how potential changes to Medicaid would harm enrollees.

[1] Medicaid Act, 42 U.S.C. § 1396.

The Importance of Medicaid

Health Status of Women of Color

Women of color are more likely to experience reproductive and other health disparities, including higher rates of unintended pregnancy, maternal mortality, and HIV/AIDS. This includes:

- Nearly 1 in 10 African American women and 1 in 14 Latinas of reproductive age experience an unintended pregnancy each year. Inaccessible and unaffordable contraceptives and abortion services contribute to these disparities. Women who are poor (under 100% of the Federal Poverty Level (FPL)) have unintended pregnancy rates twice the national average.
- African American women continue to be 3-4 times more likely than white women to die of pregnancy and its complications. The maternal mortality rate among African Americans is 20.3 per 100,000 live births compared to 5.1 for white women.[2] Often these maternal deaths could have been prevented with appropriate health information and services that conformed with recognized standards.[3]
- One-fifth of Asian American women (over 18 years of age) have never had a Pap test, and for those who have, one out of seven has not had one within the past three years.[4]
- Among adult and adolescent women in 40 states who were diagnosed with HIV in 2009, the rate of diagnosis for African Americans (47.8 of 100, 000 population) was almost 20 times the rate for whites (2.4), and more than 4 times the rate for Latinas (11.9).[5]

In addition to facing long-standing barriers to wellness and longevity, women of color and low-income women of reproductive age disproportionately experience a variety of chronic health conditions.[6] For example, the Asthma and Allergy Foundation of America noted that African American women have the highest asthma mortality rate of any racial or ethnic group, with a 2.5 times greater risk of death than white women.[7] Chronic conditions also increase the likelihood of adverse birth outcomes, such as

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[2] ST. FAM. PLAN. ADMINISTRATORS, HEALTHY PEOPLE 2010 – REPRODUCTIVE HEALTH (2010).
[3] *See generally* NATIONAL HEALTH LAW PROGRAM, HEALTH CARE REFUSALS: UNDERMINING QUALITY CARE FOR WOMEN (2010), *available at* http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf.
[4] *Id.*
[5] Dep't of Health & Hum. Services, *Centers for Disease Control & Prevention, Nat'l Center for HIV/AIDS, HIV/AIDS Prevention, HIV Surveillance in Women* – slide presentation (May 12, 2011), *available at* http://www.cdc.gov/hiv/topics/surveillance/resources/slides/women/slides/Women.pdf.
[6] Dawn P. Misra, *Racial Disparities in Perinatal Health: A Multiple Determinants Perinatal Framework with a Lifespan Approach*, 7 HARV. HEALTH POL'Y REV. 72, 81 (2006).
[7] Asthma & Allergy Found. of Am., *Asthma Facts & Figures*, *available at* http://www.aafa.org/display.cfm?id=9&sub=42#_ftn17.

preterm birth (any birth that occurs before the 37th week of pregnancy) and infant mortality.[8] To provide quality health care for these women, health services must include a comprehensive range of reproductive health services, as well as appropriate primary care to prevent and treat chronic diseases throughout the life span.

Identifying Medicaid Enrollees

Medicaid is an essential program for reproductive health services, particularly for women of color. Almost two-thirds (63%) of adult female Medicaid enrollees are in their reproductive years (ages 19 to 44). In 2010, over half of the adult women on Medicaid (58%) had incomes below 100% FPL. Twenty-eight percent of all U.S. women with incomes less than 50% of the FPL ($9,155 a year for a family of three) relied on Medicaid.[9]

Medicaid plays a critical role in providing low-income women with access to prenatal, maternity, and post-partum care and finances approximately 40% of all births in the U.S.[10] Moreover, women ages 19 to 64 in racial and ethnic groups comprised approximately half of all non-elderly Medicaid female enrollees. Specifically, in 2010, African American women were 24% of Medicaid enrollees, while Hispanic and Asian women were 20% and 4%, respectively.[11] American Indian/Aleutian Eskimo, Pacific Islander, and women of two or more races comprised 2% of female Medicaid enrollees.[12]

Poverty is usually a prerequisite for Medicaid eligibility. Women of color are more than twice as likely to live in poverty than white women (25.8% versus 11.9% respectively).[13] American Indian and Alaska Native women have the greatest poverty rates (32.8%), followed by Black (28.5%) and Hispanic women (27.4%).[14]

Medicaid Overview

Since 1965, Medicaid has been structured as an “entitlement” program that grants eligible enrollees a legal right to certain covered health services. Because Medicaid is an entitlement program, states must enroll all individuals who satisfy eligibility criteria. Medicaid is a federal-state partnership with the federal government

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[8] Misra, *supra* note 6, at 81.
[9] Kaiser Fam. Found., *Medicaid’s Role for Women Across the Lifespan: Current Issues & the Impact of the Affordable Care Act* (Jan. 2012), *available at* http://www.kff.org/womenshealth/upload/7213-03.pdf.
[10] Kaiser Health News, *Short Takes: The KHN Blog, HHS Seeks to Cut Preterm Births* (Feb. 8, 2012), *available at* http://capsules.kaiserhealthnews.org/index.php/2012/02/hhs-seeks-to-cut-preterm-births-but-medicaid-still-pays-for-them/.
[11] Kaiser Fam. Found., *Medicaid’s Role*, *supra* note 9.
[12] *Id.*
[13] Kaiser Fam. Found., *Putting Women’s Health Care Disparities on the Map* (June 2009), *available at* http://www.kff.org/minorityhealth/upload/7886.PDF.
[14] *Id.* Women in Southern states (e.g., Mississippi, Louisiana, and Alabama) experienced higher poverty rates than women in any other region of the country.

paying at least half of the costs and each state paying the rest. While participation in Medicaid is optional, all states currently participate in the program. States must meet minimum federal requirements to receive federal matching funds. The federal share, or the "Federal Medical Assistance Percentage" (FMAP) ranges from 50 to 83%.[15] States can obtain higher FMAPs for certain expenditures, such as a 90% FMAP for offering, arranging, and providing family planning services and supplies.[16]

States with lower per capita incomes receive higher FMAPs.[17] The current formula requires the federal government to pay the relevant percentage of a state's Medicaid costs with no limits. States, however, have flexibility to change eligibility and services to address changes in expenditures due to higher enrollment, increases in costs of services, and expansions of services pursuant to statutory constraints.[18]

For more details on Medicaid eligibility and services, see the Appendix to this Issue Brief.

Legislative Proposals Threaten the Structure of Medicaid

Over the past few years, Republican members of the House of Representatives offered a series of budget proposals that would change the structure and effectiveness of the Medicaid program through block grants, per-capita funding, or spending caps. All of them would fundamentally alter the current entitlement structure of Medicaid and limit access to public health insurance. While block grants or per capita caps could be designed in a way that streamlines the program or even increases funding while maintaining enrollee access and protections, the recent proposals seek to significantly reduce federal (and likely state) spending on Medicaid as part of budget cutting efforts.

Block grants provide a fixed amount of federal funds for a specific purpose. Typically, funding for block grants remain the same regardless of changes in the size of eligible populations. Recent Republican block grant proposals usually start with a state's current or recent Medicaid spending (e.g., expenditures from a previous year) to determine the fixed amount of a state's ongoing funding.[19] Once Congress sets the amount, an inflationary factor may apply but states with less income and who currently have lower levels of state Medicaid expenditures would be unable to expand their

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[15] Federal Financial Participation in State Assistance Expenditures, Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for FY 2012, 75 Fed. Reg. 69082, 69083 (Nov. 10, 2010). Currently, no state is receiving the maximum of an 83% FMAP. *See also* 42 U.S.C. § 1396d(b) (FMAP); 42 U.S.C. § 1308 (cap) (indicating that U.S. territories receive a set 50% FMAP that is subject to a spending cap). The FMAP applies to payment for the costs of most services; the federal government pays 50% of a state's administrative costs to run the program.

[16] 42 U.S.C. § 1396b(a)(5).

[17] *See, e.g.,* 74 Fed. Reg. 62,315 (Nov. 27, 2009) (differences in states' FMAPs).

[18] *See* 42 U.S.C. §§ 1396b(a), 1396d(a); Edwin Park and Matt Broaddus, *Medicaid Block Grant Would Produce Disparate and Inequitable Results Across States* (March 10, 2011), *available at* http://www.cbpp.org/files/3-10-11health.pdf.

[19] Park and Broaddus, *Medicaid Block Grant*, *supra* note 18.

Medicaid programs, increase provider payment rates, or provide coverage for new medical treatments because of the limits on the federal funds.[20] Moreover, if the inflationary factor used in block grants is not designed to address specific changing cost factors (such as health care inflation), then block grant funding would fall further behind the actual costs of care each year.[21] States would lose any amount of current federal funding that exceeds the level of the block grant. Moreover, states would likely also lose the 90% FMAP that allows them to sustain robust family planning programs.

In spite of the current recession that is reducing state budgets and increasing individuals' need for publicly funded health care services, states would have to absorb more of their Medicaid costs, with poorer states carrying the greatest financial burden. Medicaid block grants would likely result in cuts to eligibility, services and provider reimbursements as well as increases in cost-sharing for enrollees.[22] Lessons learned from the Children's Health Insurance Program (CHIP) block grant demonstrate that tens of thousands of low-income individuals could be placed on waiting lists or find themselves otherwise unable to obtain needed care.[23]

In April 2011, the Chairman of the Budget Committee of the House of Representatives, Representative Paul Ryan (R-WI), offered a FY 2012 budget proposal that would have drastically cut federal Medicaid spending over the next ten years.[24] The proposal also would have transformed Medicaid into a block grant program. Although the Senate ultimately did not approve the House budget proposal, Chairman Ryan released a similar budget resolution for FY 2013.[25]

The FY 2013 Ryan proposal cut Medicaid by a total of $1.7 trillion over the next ten years.[26] Specifically, the proposal again changes Medicaid to a block grant that

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[20] John Holahan and Alan Weil, Urban Inst., *Health Policy Online, Block Grants Are the Wrong Prescription for Medicaid*, *available at* http://www.urban.org/uploadedpdf/900624_hponline_6.pdf.

[21] *See* Edwin Park and Matt Broadus, Center on Budget & Pol'y Priorities, *Ryan Medicaid Block Grant Proposal Would Cut Medicaid by One-Third by 2022 and More After That* (Mar. 27, 2012), *available at* http://www.cbpp.org/files/3-27-12health.pdf.

[22] See *id.*

[23] Jocelyn Guyer *et al.*, Georgetown U. Health Pol'y Inst., Center for Children & Families, *CHIP: Not A Model for A Medicaid Blockgrant* (June 2011), *available at* http://ccf.georgetown.edu/wp-content/uploads/2012/03/Federal%20medicaid%20policy_CHIP-not-a-model-for-block-grant.pdf.

[24] U.S. House of Representatives, House Budget Committee, FY 2012 Budget Resolution (Apr. 5, 2011), *available at* http://budget.house.gov/uploadedfiles/pathtoprosperityfy2012.pdf. *See also* Urban Inst., *The Paul Ryan Budget Proposal* – video (April 2011), *available at* http://www.urban.org/publications/500222.html.

[25] U.S. House of Representatives, House Budget Committee, FY 2013 Budget Resolution (March 20, 2012), *available at* http://budget.house.gov/uploadedfiles/pathtoprosperity2013.pdf.

[26] U.S. House of Representatives, Committee on Energy and Commerce, Minority Staff, *Fact Sheet on Effect of Chairman Ryan's Budget on Medicaid* (March 2012), *available at* http://democrats.energycommerce.house.gov/sites/default/files/documents/FactSheet_RyanBudget_03.2012.pdf.

decreases funding to states by $810 billion (or 22%) over ten years.[27] The proposal also would repeal the ACA's Medicaid Expansion which further cuts the program by $931 billion over ten years.[28] This new structure would shift from the shared responsibility with the federal government to state Medicaid programs being solely responsible for responding to potential economic recessions and local natural disasters.

Senators Bob Corker (R-TN) and Claire McCaskill (D-MO) sponsored a bill (S. 245) to impose an absolute "spending cap" on federal spending to no more than 20.6% of the Gross Domestic Product.[29] If federal spending exceeded the "cap" (regardless of the reason), a sweeping automatic cut in federal funding of discretionary and mandatory programs (called a "sequester") would limit federal spending and reduce it to the level of the cap.[30] Restrictive federal spending caps (like S. 245) can produce the same effect of providing extremely limited funding for Medicaid.[31] The McCaskill-Corker bill was referred to the Senate Committee on the Budget, where it died at the end of the 112th Congress. The legislation could be reintroduced during the next session or as part of debt reduction negotiations.

In June 2012, Representative Bill Cassidy (R-LA) introduced the Medicaid Accountability and Care (MAC) Act of 2012 (H.R. 5979).[32] Among other provisions, the bill would implement a per-capita cap adjusted by Medicaid eligibility category.[33] The federal government would pay states a fixed dollar amount for each Medicaid enrollee (per capita), as opposed to covering a specific share of states' overall Medicaid costs.[34] The bill adopts a payment structure by eligibility group and assigns payments based on a per-capita and per-category basis for the elderly, children, other adults, individuals who are blind, and individuals with other disabilities.[35]

H.R. 5979 would give all states an estimated 76% FMAP.[36] For some states, this would mean an increase in federal funding (for example California, Illinois,

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[27] *Id.*
[28] *Id.*
[29] Commitment to American Prosperity Act, S. 245, 112th Cong. (2011). *See also* Commitment to American Prosperity Act, H.R. 1605, 112th Cong. (2011). The House version of the bill is identical to the Senate version. *See also* Coalition on Human Needs, *Medicaid Program at Risk* (May 31, 2011), *available at* http://www.chn.org/humanneeds/110531a.html (noting that current federal spending is between 24 – 25% of the Gross Domestic Product).
[30] Guyer *et al.*, *supra* note 23.
[31] *See* Coalition on Human Needs, *supra* note 29.
[32] Medicaid Accountability and Care Act of 2012, H.R. 5979, 112th Cong. (2012).
[33] CWLA, Children's Monitor, *Medicaid Accountability & Care Act of 2012*, *available at* http://childrensmonitor.wordpress.com/2012/06/21/medicaid-accountability-and-care-act-of-2012/.
[34] Edwin Park and Matt Broaddus, Center on Budget & Pol'y Priorities, *Medicaid Per Capita Cap Would Shift Costs to States and Place Low-Income Beneficiaries at Risk* (Oct. 4, 2012), *available at* http://www.cbpp.org/files/10-4-12health.pdf .
[35] H.R. 5979, § 1903A(b).
[36] *Id.*

Massachusetts, and 11 other states receive a 50% FMAP in FY 2012).[37] The poorest states, in contrast, could receive a decrease in federal funding (Mississippi receives 74.18% FMAP in FY 2012).[38] The bill could also negatively impact the health of low-income women seeking coverage of abortion services. Specifically, if a state covers abortion services with state funds, it cannot also use state funds to pay its share of Medicaid costs for abortions.[39] While H.R. 5979 might appear to be an increase in FMAP for some states, limits on what states can include for the federal match could actually increase the states' share of costs.

The Ryan proposals to convert Medicaid into a block grant program and the McCaskill-Corker bill to institute a spending cap in federal programs would have both resulted in severe cuts in Medicaid eligibility and services. The Cassidy bill would not only limit federal spending for Medicaid, but infringe upon women's reproductive health services. All of these proposals particularly impact poorer states, which would exacerbate existing health disparities among women of color and other communities of low-income women.

Conclusion

Recent legislative proposals to change Medicaid's structure have not been enacted to date. Yet, these proposals could resurface under the cloak of a solution for states facing fiscal challenges or for the federal government seeking to reduce the deficit. In reality, block grants, per-capita, and federal spending cap proposals would eliminate the incentive and the ability of less affluent states to provide coverage for the full scope of mandatory and optional services to eligible low-income residents. Moreover, women of color, rural women, and other women living in poverty who depend on Medicaid would likely encounter increased cost-sharing and restrictions of needed services and screenings to address lingering reproductive and overall health disparities. Without access to Medicaid coverage for family planning services and supplies, prenatal care, primary care services, and screenings and treatments for HIV/AIDS and STIs, women of color and low-income women will continue to experience poor health status and birth outcomes.

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[37] Federal Financial Participation in State Assistance Expenditures, Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for FY 2012, 75 Fed. Reg. 69082,69083 (Nov. 10, 2010).

[38] *Id.*

[39] H.R. 5979, 112th Cong., § 1903A(a)2(E)(ii) (2012).

Appendix

Medicaid Eligibility

Not all individuals with low incomes are eligible for Medicaid under current Medicaid rules. Applicants must meet all of the following criteria: fit into an eligibility category ("categorical eligibility") such as pregnant women, children and their caretakers, elderly individuals, and people with disabilities; satisfy income and resources limits; have United States citizenship or meet the definition of a lawfully present immigrant; and reside in the state where applying for Medicaid.[40]

The current criteria exclude low-income individuals with serious health conditions but who have not yet been determined as having a disability (e.g., women with HIV who have not yet reached the stage of full-blown AIDS), and low-income childless adults such as young adults, older women under age 65 with adult children, and women – including lesbians – who are not parents.

States must enroll individuals who meet certain eligibility requirements. Mandatory categories include, among others, pregnant women and children up to age 6 with family incomes of up to 133% FPL.[41] States are also required to cover children 6 to 19 years of age with family incomes of up to 133% FPL.[42]

States have the option of providing Medicaid coverage for infants under one year of age and pregnant women with incomes up to 185% FPL (about $15,130 per year for a single mother with one child), as well as other groups, such as women with breast and cervical cancer.[43] States can also opt to provide coverage to the fetuses of undocumented pregnant women through the Children's Health Insurance Program (CHIP) and receive prenatal care.[44]

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[40] 42 U.S.C. §1641; 42 U.S.C. § 1396b(v). Lawfully present immigrants who arrive in the U.S. after August 22, 1996 are prohibited from enrolling in Medicaid for at least five years. However, Medicaid will cover treatment for emergency medical conditions for these individuals and undocumented persons if they otherwise meet Medicaid eligibility requirements; 42 C.F.R. § 435.403.

[41] 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV),(VI); 42 U.S.C. §§ 1396a(l)(1)(A)-(C), 2(A), (B).

[42] ACA § 2001 (effective as of January 1, 2014).

[43] *See, e.g.*, Breast and Cervical Cancer Prevention and Treatment Act of 2000, Pub. L. No. 106-354, 114 Stat. 1381. Low-income and uninsured women can obtain full Medicaid coverage for the time period that they need treatment of breast and cervical cancer. *See also* 42 U.S.C. § 1396a(aa). The HHS Centers for Disease Control and Prevention (CDC) early detection program must screen women seeking Medicaid coverage for breast or cervical cancer to determine eligibility.

[44] CMS, CMCS Informational Bulletin (July 9, 2010). The Children's Health Insurance Program Reauthorization Act of 2009 enacted this option for the states.

In 2014, the Patient Protection and Affordable Care Act (ACA) will be fully implemented, including a mandatory expansion of Medicaid eligibility.[45] Beginning in 2014, states must enroll low-income adults who are under 138% FPL, which is $30,843 for a family of four in 2011.[46] As of April 1, 2010, states could begin providing Medicaid coverage to these newly eligible individuals earlier than 2014 by filing a state plan amendment with the Centers for Medicare & Medicaid Services (CMS).[47]

The federal government pays 100% of the cost of enrolling newly-eligible individuals for 2014 – 2016.[48] After 2016, the federal government begins to reduce its payments so that by 2020 states pay 10%.[49] Women will significantly benefit from the Medicaid Expansion since up to10 million uninsured women will become newly eligible (based on their current income levels).[50]

The Supreme Court examined the ACA's Medicaid Expansion in *National Federation of Independent Business v. Sebelius* (*NFIB*) and ruled in 2012 that Congress could not force states to expand Medicaid eligibility under the threat of losing all existing federal funding for the traditional eligibility categories.[51] However, the *NFIB* decision did not eliminate the ACA's mandate for states to comply with the mandatory Medicaid eligibility expansion in 2014. In spite of this requirement, several governors have objected to the expansion or not indicated whether their states will comply with it.

Scope of Services

The Medicaid Act mandates coverage of certain services, including inpatient and outpatient hospital services, physician services, laboratory and radiology services, family planning services and supplies, and non-emergency medical transportation and related travel expenses.[52] The law also mandates coverage of pregnancy-related

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[45] Patient Protection and Affordable Care Act, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [hereafter ACA]; 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).
[46] *See* Kaiser Fam. Found., *Focus on Health Reform: Determining Income for Adults Applying for Medicaid and Exchange Coverage Subsidies* (March 2011), *available at* http://www.kff.org/healthreform/upload/8168.pdf (describing how the ACA sets a new national minimum level of Medicaid coverage at 133% FPL with a standard income disregard of 5% that raises the limit to 138% FPL in 2014).
[47] CMS, Dear State Health Official/Medicaid Director (April 9, 2010).
[48] Cong. Res. Service, *Medicaid: The Federal Medical Assistance Percentage (FMAP)* 11 (Sept. 24, 2010), *available at* http://aging.senate.gov/crs/medicaid6.pdf.
[49] *Id.*
[50] Kaiser Fam. Found., *Medicaid's Role for Women Throughout the Lifespan: Current Issues & the Impact of the Affordable Care Act, Women's Issue Brief – An Update on Women's Health Policy* (Jan. 2012), *available at* http://www.kff.org/womenshealth/upload/7213-03.pdf.
[51] 567 U.S. __, 132 S. Ct. 2566 (2012). *See* 42 U.S.C. § 1396a(a)(10)(A)(i) (describing mandatory Medicaid eligibility groups).
[52] *See, e.g.,* 42 U.S.C. § 1396d(a)(4)(C); 42 C.F.R. § 441.20 (family planning services and supplies); 42 C.F.R. § 431.53. *But see* 72 Fed. Reg. 48604-05 (Aug. 24, 2007) (describing state flexibility in determining non-emergency modes of transportation for medical treatment).

services, including services for conditions that might complicate pregnancy, 60-day post-partum related services, and nurse midwife services.[53]

In addition, the federal government gives states the option to cover 23 other services, such as prescription drugs, dental services, physical and related therapies, and home health services.[54] Some of these services will become mandatory in 2014 for newly-eligible enrollees.[55]

Amendments to the Medicaid program in 1972 established a legal entitlement to family planning services for Medicaid enrollees nationwide. Thus, the Medicaid Act requires coverage of "family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered as sexually active) who are eligible under the State plan and who desire such services and supplies."[56]

Family planning services and supplies were given a special FMAP of 90%.[57] As a result, the federal government pays most of the costs for reproductive health screenings and services, including contraceptives, Pap smears, STI screenings and treatment, and counseling.

Prior to the ACA, states could expand access to family planning services and supplies to individuals not eligible for traditional Medicaid through a § 1115 demonstration project (also known as a waiver).[58] The ACA now allows states to create a new optional Medicaid eligibility category to provide family planning services to men, women, and adolescents not eligible for traditional Medicaid through a State Plan Amendment (SPA) which is easier to achieve than a waiver. As of October 2012, 31 states have expanded their family planning programs through a waiver or a SPA.[59]

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[53] 42 U.S.C. §§ 1396a(a)(10)(A), (C), 1396a(l), 1396d(n) (defining qualified pregnant woman); 42 C.F.R. §§ 440.210(a)(2) (allowing greater amount, duration and scope of pregnancy services).
[54] *See* 42 U.S.C. §§ 1396d(a)(12), 1396d(a)(10), 1396d(a)(11), 1396d(a)(27). *See also* 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(r). States must also cover Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children and adolescents who are under age 21. EPDST services include periodic medical, vision, hearing, and dental examinations, age-appropriate health education, and treatment services to "correct or ameliorate" physical or mental problems, including case management.
[55] 42 U.S.C. § 1396u-7(a)(5) (referring to Essential Health Benefits which states must provide to all newly eligible individuals; these include, ambulatory services, inpatient care, laboratory services, prescription drugs, and chronic disease management).
[56] 42 U.S.C. § 1905(a)(4)(C).
[57] 42 U.S.C. § 1903(a)(5).
[58] 42 U.S.C. § 1315. Section 1115 is the provision of the Social Security Act giving the Secretary of HHS the authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs.
[59] Guttmacher Inst., *State Policies in Brief: Medicaid Family Planning Eligibility Expansions as of October 1, 2012* (Oct. 1, 2012), *available at* http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf.

Further details on Medicaid coverage of reproductive health services are described in NHeLP's publication, *An Advocate's Guide to Reproductive Health in the Medicaid Program*.[60]

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[60] NATIONAL HEALTH LAW PROGRAM, AN ADVOCATE'S GUIDE TO REPRODUCTIVE HEALTH IN THE MEDICAID PROGRAM (2010) and the ACA Update, *available at* http://www.healthlaw.org/images/stories/NHeLP_ReproMedicaid_Guide_11.pdf; http://www.healthlaw.org/images/stories/2011_09_26_NHeLP_Repro_Advocates_Guide.pdf.