



Protect Medicaid Funding Issue #7: Access to Reproductive and Sexual Health Care

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Introduction

Medicaid helps people live healthier and more economically secure lives. It increases the diagnosis and early treatment of chronic conditions, enhances educational achievement and future earnings for covered children, reduces health care inequities, and provides comprehensive, high-quality, and cost-effective care.¹ Medicaid coverage is tailored to the unique needs of individuals and families with low incomes, but still costs less per beneficiary than private insurance.² Medicaid's core beneficiary protections make the program work for enrolled populations, including children, parents, pregnant people, low-income workers, older adults, and people with disabilities. Despite Medicaid's proven success and efficient use of funds, detractors repeatedly seek to cut or cap funding for the program. These proposals seriously jeopardize the health and financial security of the 91.8 million people who benefit from Medicaid and CHIP.³

This fact sheet explains why Medicaid is critical for people who need access to reproductive and sexual health care, and in particular, women and lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) people.

Why Medicaid is Critical to Reproductive and Sexual Health Care Access

As the country's largest public health insurance program, Medicaid plays a crucial role in the struggle for equitable access to reproductive and sexual health care.

Medicaid covers more than forty percent of U.S. births, sixty-five percent of births for Black women and birthing people, and is the leading source of coverage for family planning services in the U.S.⁴ States are required to cover family planning services and supplies (FPSS), certain pregnancy-related services, and abortions within the Hyde amendment's exceptions (*i.e.*, when the pregnancy results from rape and/or incest, or when it endangers the pregnant person's life). All states, territories, and DC cover Medicaid's optional outpatient prescription drug benefit, which means they must cover medications critical to reproductive and sexual health.⁵

Moreover, all states have taken up the Breast and Cervical Cancer Treatment Program option to extend Medicaid coverage for people diagnosed with breast and cervical cancer.⁶ Many Medicaid programs also cover aspects of gender-affirming care, which are essential to helping transgender and nonbinary people reach their highest attainable standard of sexual and reproductive health.⁷ Some states also cover aspects of assisted reproduction, such as in vitro fertilization, which are critical for people who grapple with infertility, such as people with chronic conditions and other disabilities that affect their fertility, and many LGBTQI+ people.⁸

Medicaid provides critical coverage for people who need family planning services and supplies. Under Medicaid law, all states must cover FPSS without cost-sharing for individuals who want to prevent pregnancy.⁹ Furthermore, Medicaid includes a number of special protections to ensure that people can access FPSS: Medicaid requires states to give people “freedom of choice” to visit any Medicaid provider to obtain FPSS (including providers outside an enrollee’s managed care plan) and provides states with a ninety percent federal medical assistance percentage (FMAP) for FPSS, giving states a strong incentive to provide these services.¹⁰ Medicaid also allows states to provide FPSS to many individuals not otherwise eligible for Medicaid. The resulting limited-scope family planning coverage is especially important in states that have not expanded Medicaid.¹¹

Funding Caps Would Curtail Access to Care

Funding caps threaten the coverage of millions of people. Block grants and per capita cap proposals reduce the amount of federal funding available to states to help provide essential reproductive and sexual health care. 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 their income eligibility threshold for pregnancy-related Medicaid or drop critical optional programs such as coverage for people with breast and cervical cancer or limited-scope family planning coverage, causing millions of people to lose coverage.

Funding caps could lead states to reduce the availability of critical services. States struggling to fund their Medicaid budgets would likely reduce the services available to the people who remain eligible. For example, states could narrow the list of covered pregnancy-related services. States could also impose limits that would harm people with low incomes with disabilities. A state might attempt to drop their outpatient prescription drug benefit or limit the number of prescriptions a person can fill per month, leaving people with chronic conditions such as HIV, endometriosis, and polycystic ovary syndrome without essential and potentially lifesaving medications.

Funding caps would weaken access to contraceptive care. Under the financial pressure from funding caps, states might also seek to roll back or request exceptions to federal standards that ensure access to contraceptive care. Federal regulators might waive the freedom of choice requirement that allows people to visit any family planning provider of their choice. States may mistakenly believe that placing people in restrictive FPSS provider networks could “save” money in the short-term, but doing so would increase the rate of unintended pregnancies. This would not only negate any real savings, but also deprive people of the means to determine their reproductive and health futures. States would also likely shift costs onto people with low incomes 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 people and their families. Policy proposals to cap or cut Medicaid may also include proposals to gut important federal protections for pregnant people. For example, federal law requires that state Medicaid programs provide pregnancy-related coverage until roughly sixty days after pregnancies end.¹² Since 2021, more than half of states have taken up the American Rescue Plan Act’s new state plan amendment option to extend pregnancy-related coverage to a full year after pregnancies end.¹³ Extending pregnancy-related coverage is critical in the fight to end the maternal mortality crisis, especially for African Americans.¹⁴ Without adequate funding, states might drop these optional extensions in coverage.

ENDNOTES

- 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), <http://care.diabetesjournals.org/content/38/5/833> (Medicaid coverage improves diabetes screening and treatment initiation); Owen Thompson, *The Long-Term Health Impacts of Medicaid and CHIP*, 51 J. HEALTH ECON. 26 (2017), <https://www.sciencedirect.com/science/article/abs/pii/S0167629616305136?via%3Dihub>; Sarah Miller & Laura R. Wherry, *The Long-Term Effects of Early Life Medicaid Coverage*, 54 J. HUMAN RES. 785-824 (2019), <http://jhr.uwpress.org/content/54/3/785> (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), <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2016.303155> (Medicaid expansion reduced health care disparities); Robin Rudowitz et al., Kaiser Fam. Found., *10 Things to Know about Medicaid: Setting the Facts Straight* (March 6, 2019), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>; Hannah Katch, Ctr. on Budget & Pol’y Priorities, *Medicaid Works: Millions Benefit from Medicaid’s Effective, Efficient Coverage* (June 2, 2017), <https://www.cbpp.org/research/health/medicaid-works-millions-benefit-from-medicaid-effective-efficient-coverage>.
- ² Hannah Katch et al., Ctr. on Budget & Pol’y Priorities, *Frequently Asked Questions About Medicaid* (Nov. 22, 2019), <https://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid> (Private insurance costs twenty-two percent more than covering the same low-income individual with Medicaid).
- ³ CMS, November 2022 Medicaid & CHIP Enrollment Data Highlights (Feb. 28, 2023), <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.
- ⁴ In this fact sheet, we strive to use gender inclusive language to reflect the scope of people with various reproductive and sexual health care needs and reproductive experiences. We employ “women” in limited instances when necessary to accurately communicate statutory terms or cisgender women-centered research. More inclusive statutory terms and research is needed. Medicaid & CHIP Payment & Access Comm’n, *Medicaid’s Role in Financing Maternity Care* 1, 5 (Feb. 2021), <https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf>; Usha Ranji et al., *Financing Family Planning Services for Low-income Women: The Role of Public Programs*, Kaiser Fam. Found. (Oct. 25, 2019), <https://www.kff.org/womens-health-policy/issue-brief/financing-family-planning-services-for-low-income-women-the-role-of-public-programs/>.

⁵ 42 U.S.C. § 1396r-8(d) (requiring that states that cover the optional prescription drug benefit cover outpatient drugs of any manufacturer participating in the Medicaid Drug Rebate Program); Medicaid & CHIP Payment & Access Comm'n, *Medicaid and CHIP in the Territories* (Feb. 2021), <https://www.macpac.gov/wp-content/uploads/2019/07/Medicaid-and-CHIP-in-the-Territories.pdf>; CMS, Drug Products in the Medicaid Drug Rebate Program, <https://data.medicaid.gov/dataset/0ad65fe5-3ad3-5d79-a3f9-7893ded7963a/>.

⁶ Kaiser Fam. Found., State Eligibility for Medicaid Breast and Cervical Cancer Treatment Program (BCCTP), <https://www.kff.org/other/state-indicator/state-eligibility-for-medicaid-breast-and-cervical-cancer-treatment-program-bcctp/>.

⁷ Ivette Gomez et al., Kaiser Fam. Found., *Update on Medicaid Coverage of Gender-Affirming Health Services* (Oct. 11, 2022), <https://www.kff.org/womens-health-policy/issue-brief/update-on-medicaid-coverage-of-gender-affirming-health-services/>.

⁸ Gabriela Weigel, Kaiser Fam. Found., *Coverage and Use of Fertility Services in the U.S.* (Sept. 15, 2020), <https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s/>.

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

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

¹¹ Kaiser Fam. Found., States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid, <https://www.kff.org/medicaid/state-indicator/family-planning-services-waivers/>.

¹² 42 U.S.C. § 1396a(e)(6).

¹³ American Rescue Plan Act of 2021, Pub. L. No. 1172, 117th Cong. § 9812(a) (2021) (amending 42 U.S.C. 1396a(e)); Kaiser Fam. Found., Medicaid Postpartum Coverage Extension Tracker, <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/> (finding that as of March 9, 2023, twenty-nine states including DC have implemented twelve months of coverage after pregnancies end).

¹⁴ Madeline T. Morcelle, *Reforming Medicaid Toward Reproductive Justice*, 48 AM. J. OF LAW & MED. 223, 235 (2022) (discussing how the Medicaid Act's roughly sixty-day duration of pregnancy-related coverage does not go nearly far enough to protect postpartum people from pregnancy-related morbidity and mortality, which often manifest much later).