Medicaid’s Role for Women

Medicaid, the nation’s health coverage program for poor and low-income people, provided more than 25 million low-income women with health and long-term care coverage in 2014. Women comprise the majority of adult Medicaid beneficiaries—before the passage of the Affordable Care Act (ACA) and today. The program provides beneficiaries with a wide range of primary, preventive, specialty, and long-term care services important to women across their lifespans. Federal policymakers and Congress are debating a replacement plan for the ACA that could fundamentally reshape Medicaid and reduce federal Medicaid spending. Given the critical lifeline that the program provides for low-income women and their families, changes to the program financing and structure could have significant implications for low-income women’s access to coverage and care. This factsheet presents key data points describing the current state of the Medicaid program as it affects women.

WHO IS ELIGIBLE FOR COVERAGE?

In 2014, women comprised the majority of the adults and 36% of the overall Medicaid population (Figure 1). Prior to the ACA, women were more likely to qualify for Medicaid because of their lower incomes and because they were more likely to belong to one of Medicaid’s categories of eligibility: pregnant, parent of a dependent child, senior, or disability. The ACA, as signed by President Obama, eliminated these categories by extending Medicaid eligibility to all individuals with incomes up to 138% of the federal poverty level (FPL). The 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius however made the Medicaid expansion optional for states, resulting in inconsistent coverage policies across the country.

- As of June 2017, 31 states and DC have expanded eligibility for Medicaid which allows low-income women with incomes below 138% FPL in these states who are not pregnant or do not have children to qualify for coverage.
In the 19 states that have not expanded Medicaid, adults only can qualify if they meet income criteria and belong to one of the eligibility categorical groups: pregnant women, parents with dependent children, seniors, or disability. States set specific eligibility levels for each group. As a result, eligibility criteria vary for different groups of beneficiaries as well as between states, and eligibility levels are much lower for parents in the states that have not expanded Medicaid, ranging from 18% FPL in Alabama and Texas, to 105% FPL in Maine (Figure 2).

**PROFILE OF WOMEN ON MEDICAID**

The diverse population of women on Medicaid face many social, economic, and health challenges that affect their ability to receive timely and high quality health care.

- Almost in 10 (27%) nonelderly women on Medicaid report fair or poor health, compared to 6% of women with private employer-sponsored coverage and 11% of women who are uninsured.5
- Over half of women on Medicaid work outside the home (56%). Many others are caring for family members (18%), have a serious illness or disability (12%), or attend school (6%). Approximately six in ten mothers (62%) are working and another quarter are caring for family members. Among women without children, half (49%) are working and another 19% have an illness or disability (Figure 3).
- Nationally, Medicaid covers 17% of nonelderly women in the United States, but coverage rates are much higher among certain groups, such as minority women, single mothers, low-income women, and women who
rate their health status as fair and/or poor health (Figure 4). Medicaid coverage rates also vary across states, from 7% in Virginia and Kansas to 30% in West Virginia (Figure 5).

**Reproductive Health**

Roughly two-thirds (67%) of adult women on Medicaid are in their reproductive years (19 to 49). Medicaid covers a wide range of reproductive health care services, including family planning, STI testing and treatment, and pregnancy-related care including prenatal services, childbirth, and postpartum care. Medicaid coverage of abortion services, however, is very limited.

**Family planning**

Federal law requires state Medicaid programs to offer family planning benefits, but states determine the specific services and supplies for those who qualify through pre-ACA pathways. For the ACA expansion populations, the ACA requires states to cover 18 FDA approved contraceptive methods, counseling on STIs and HIV, and screening for breast and cervical cancers. Research has found that most states cover these services across all eligibility groups.

- Nationally, Medicaid is the largest financier of publicly funded family planning services, accounting for 75% of all public expenditures. The federal government provides states with an enhanced match of 90% for family planning, a higher rate than for other services (typically matched at a rate between 50% and 76%). Women covered by Medicaid cannot be charged any out-of-pocket costs for family planning services, and the federal government also guarantees “freedom of choice” for Medicaid beneficiaries, which allows them to obtain family planning services from any provider that participates in the program, even to seek care from an out-of-network provider if they are enrolled in a managed care organization.
• Under current Medicaid policy, states must allow “any willing provider” to participate in the Medicaid program unless there is “evidence of fraud or criminal action, material non-compliance with relevant requirements, or material issues concerning the fitness of the provider to perform covered services or appropriately bill for them.” While this provision is not specific to family planning, the policy means that states cannot bar providers from the program simply because they provide abortion services. This policy has been in the spotlight in recent years as some federal and state policymakers attempt to block Medicaid reimbursement payments from going to Planned Parenthood.

• Twenty-seven states have established limited scope Medicaid family planning programs to extend access to family planning services to uninsured women who do not qualify for full Medicaid coverage. This includes low-income women who are not poor enough to qualify for Medicaid or who have lost Medicaid eligibility after having a baby.

Maternity Care:
Medicaid is the largest single payer of pregnancy-related services, financing 48% of all U.S. births in 2010. In five states and DC, Medicaid covers more than 60% of all births (Figure 6). By federal law, all states provide Medicaid coverage without cost sharing for pregnancy-related services to pregnant women with incomes up to 133% of the federal poverty level (FPL) and cover them up to 60 days postpartum.

• Similar to family planning, there is no federal definition of what services states must cover under their traditional Medicaid programs for pregnant women beyond inpatient and outpatient hospital care, but states that have expanded Medicaid eligibility must cover all preventive services recommended by the United States Preventive Services Task Force (USPSTF) to individuals who qualify through this pathway. Overall, most states cover a broad range of perinatal services across eligibility pathways, including prenatal screenings, folic acid supplements, and breastfeeding supports.

• Prior the ACA, states’ income eligibility thresholds for parents were typically much lower than the federal minimum of 133% FPL for pregnant women. This meant that many women would lose Medicaid coverage 60 days after the birth of their child. In the 19 states that have not adopted the ACA’s Medicaid expansion this is still the case, but in states that did expand eligibility, many women are now able to remain on Medicaid once they become mothers because of the higher income eligibility threshold used in these states.
Abortion
The federal Hyde Amendment prohibits federal spending on abortions, except in cases of rape, incest, or when the woman’s life is in danger (Figure 7). States may use their own unmatched funds to cover abortions in other circumstances. As of June 2017, 15 states cover abortions for Medicaid beneficiaries that are considered to be “medically necessary” and pay for these using only state funds.

CHRONIC CONDITIONS AND DISABILITIES
As women age, their health needs shift from reproductive care to greater need for screening and management of chronic diseases, mental health care, and disability care (although many women in their reproductive years also have these health needs).

Mental Health
- Medicaid is a primary payer of mental health services in the U.S. In 2015, Medicaid covered approximately nearly one in four (23%) adult women with any mental illness and 28% of adult women with a serious mental illness.\(^\text{10}\)

- Medicaid’s behavioral health benefits include acute care services, long-term services, and supports to enable people with chronic illness to receive community-based care.\(^\text{11}\) In addition, states with Medicaid expansion programs are required to cover 10 essential health benefits, which include mental health and substance use disorder services, including behavioral health treatment.

Breast and Cervical Cancers
- Under the Breast and Cervical Cancer Prevention and Treatment Act, states may extend Medicaid coverage for cancer treatment to uninsured women diagnosed with breast or cervical cancer through a federal screening program and receive a federal match for those services.

- Preventive services for breast and cervical cancers are required benefits in ACA Medicaid Expansion programs. States are required to cover mammograms and pap tests, genetic (BRCA) screening for high-risk women, and breast cancer preventive medication for high risk women. While coverage of these services are optional under traditional Medicaid and family planning-specific programs, most states cover the screening tests for all beneficiaries. However, coverage for other services such as such as colposcopy following an abnormal pap result and preventive medication for women at higher risk of breast cancer is more uneven across state eligibility pathways.\(^\text{12}\)
Medicaid’s Role for Women

Women with disabilities

- Medicaid plays a critical role financing care for women with disabilities, providing assistance with a variety of medical and supportive services. Among the benefits that Medicaid covers are rehabilitation, transportation, and therapeutic services, which help people with disabilities live independently and are not typically covered by private health insurance plans. Long-term services, including home health care, are another major health benefit for women with disabilities.

- Medicaid covers more than one in three (35%) nonelderly women with disabilities (Figure 8). People with disabilities account for 15% of total Medicaid enrollment but 45% of program spending due to their greater health needs and more intensive service use.13

- These women have a broad range of physical and mental disabilities, including physical impairments, severe mental illnesses, and specific conditions such as muscular dystrophy, cystic fibrosis, and HIV/AIDS.

Aging and Long-Term Care

While most seniors have coverage through Medicare, many who are very low-income can also qualify for Medicaid, and are referred to as “dual eligible.” Dual eligible beneficiaries typically qualify for both programs because they are 65 and older or younger persons with serious disabilities who have very low incomes. They tend to have extensive health needs, but only those who are very poor or face very high medical costs can qualify.

- There are 11 million dual eligibles, and women account for 60% of this group.14 Dual eligible beneficiaries fall into two groups. Most have full-scope Medicaid and receive coverage for services that Medicare does not currently cover, such as nursing home stays and dental and vision care. This group also receives Medicaid coverage for Medicare’s out-of-pocket costs, such as deductibles and co-payments. Dual eligible beneficiaries with slightly higher incomes receive partial Medicaid, which is limited to assistance with some of Medicare’s out-of-pocket costs, such as premiums and cost sharing.

- Medicaid finances more than half (53%) of long-term care expenditures,15 in part, because Medicare does not cover these services and private long-term insurance is very expensive and unaffordable for many people.

- Since women are more likely to live longer and experience higher rates of chronic illness and disability than men, they are more likely to require long-term services in their lifetime. Approximately two-thirds of nursing home residents (66%)16 and people receiving home health care (62%) are women.17 Medicaid coverage gives access to these critical long-term services, which would otherwise be beyond the range of affordability for women with fixed incomes (nursing home care averages more than $82,125 annually).18
Compared to their uninsured counterparts, women with public coverage experience fewer barriers to care and on several measures have utilization rates comparable to women with private insurance.

- Women on Medicaid use primary and preventive health services, such as pap smears and mammograms, at rates comparable to women with private insurance and at higher rates than uninsured women (Figure 9).

- Women on Medicaid are less likely than uninsured women to experience cost barriers, but affordability is still a problem for some women in the program. Some states impose caps on the number of covered visits or prescriptions or copayments for prescription drugs (for non-pregnant adults) can limit access for low-income Medicaid beneficiaries. Approximately one in 10 women on Medicaid report that they had not filled a prescription (12%) in the past year because of the cost. Some also reported cost as a problem seeing a specialist or obtaining follow-up care, but the rate was considerably lower than for uninsured women (Figure 10).
Endnotes

1 This estimate is based on limited data from several states. Total enrollment currently is likely higher as this does not include some states and does not capture the full effect of the ACA expansion.

2 Kaiser Family Foundation estimates based on 2014 Medicaid Statistical Information System (MSIS)

3 Kaiser Family Foundation estimates based on 2014 MSIS.

4 138% Federal Poverty Level in 2016 was $16,394 per year for individuals.


19 Kaiser Family Foundation analysis of 2015 National Health Interview Survey.

20 Kaiser Family Foundation analysis of 2015 National Health Interview Survey.