March 2019 | Fact Sheet

Medicaid's Role for Women

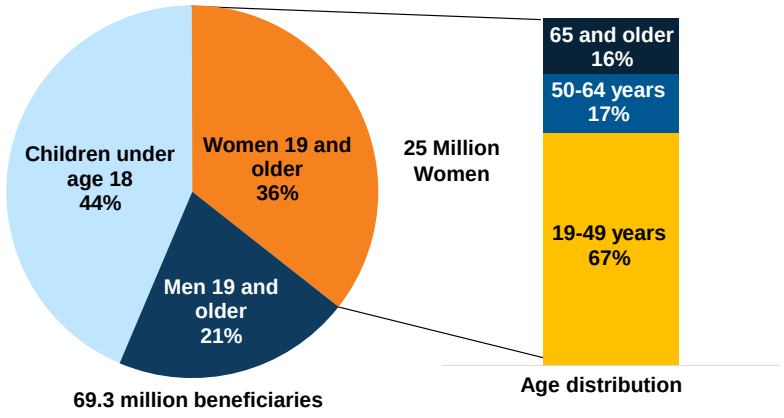
Medicaid, the nation's health coverage program for poor and low-income people, provides millions of low-income women across the nation with health and long-term care coverage. Women comprise the majority of the adult Medicaid population—before the passage of the Affordable Care Act (ACA) and today. For women, the program offers coverage of a wide range of primary, preventive, specialty, and long-term care services which are important to them across their lifespans. Given the critical lifeline that the program provides for low-income women and their families, changes to the program financing and structure 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, the most recent date that national enrollment statistics are available, women comprised 36% of the overall Medicaid population and the majority of adults on the program (**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).[1] 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.

Figure 1

Medicaid Covers 25 Million Adult Women in the United States



NOTE: 2014 data unavailable for AK, CO, FL, KS, NC and RI and for all four quarters of AL, DC, DE, IL, KY, MD, ME, MT, ND, NE, NH, NM, NV, SC, TX, VA, & WI; excluded from US totals.
SOURCE: Kaiser Family Foundation estimates based on 2014 Medicaid Statistical Information System (MSIS).

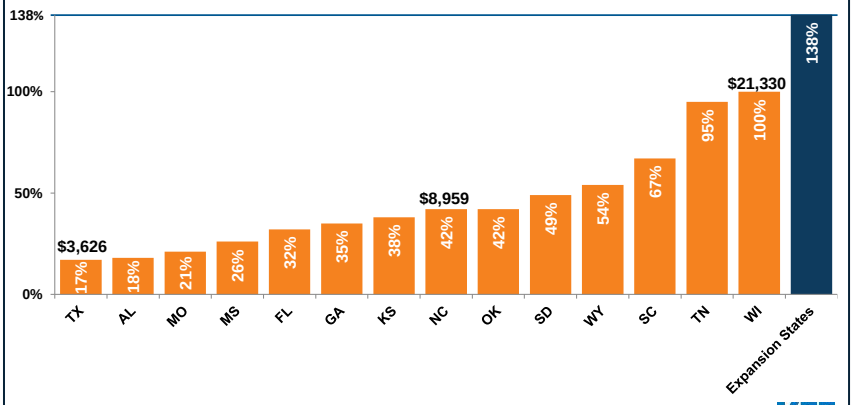
- As of February 2019, 36 states and DC have opted to expand eligibility for Medicaid, which allows low-income women with incomes below 138% FPL regardless of their pregnancy, parenting or disability status.

- In the 14 states that have not expanded Medicaid, adults only qualify if they meet income criteria AND belong to one of the eligibility categorical groups: pregnant women, parents with dependent children, seniors, or those with a disability. States set eligibility levels for each group. As a result, income eligibility criteria vary for different groups of beneficiaries within as well as between states. Eligibility levels are much lower for parents in the states that have not expanded Medicaid, ranging from 17% FPL in Texas, to 100% FPL in Wisconsin (**Figure 2**).

Figure 2

Medicaid Income Eligibility Limits for Parents are Lower in States that Have Not Implemented the Medicaid ACA Expansion

Medicaid eligibility thresholds for parents, 2019



NOTE:NOTE: Eligibility limits calculated as a percent of the Federal Poverty Level (FPL) & are calculated based on a family of three for parents. In 2019, the FPL was $21,330 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.

Profile of Women on Medicaid

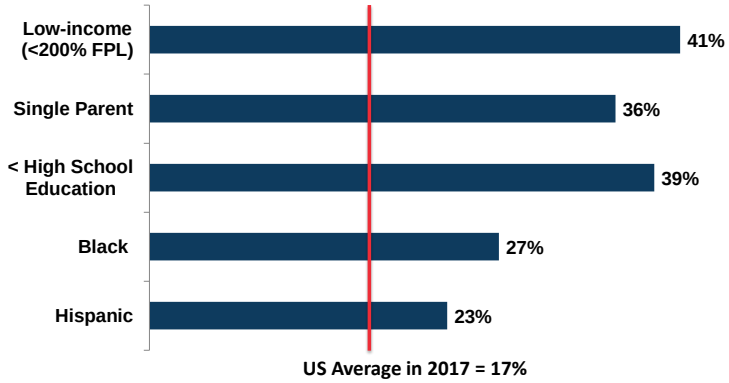
The diverse population of women covered by Medicaid face many social, economic, and health challenges that affect their ability to receive timely and high quality health care.

- In 2017, Medicaid covered 17% of nonelderly women in the United States, but coverage rates were much higher among certain groups, such as minority women, single mothers, low-income women, and women who have not completed a high school education (**Figure 3**).

Figure 3

Medicaid Covers a Disproportionate Share of Women in Vulnerable Populations

Percentage of women ages 19 to 64 years who are:



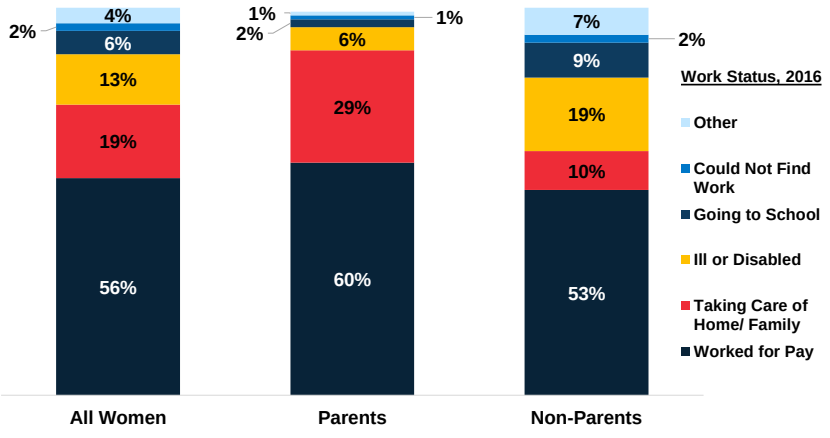
NOTE: 200% of the Federal Poverty Level (FPL) was $24,120 for an individual in 2017.
SOURCE: Kaiser Family Foundation estimates based on 2017 Census Bureau's American Community Survey.

- Over half of nonelderly women on Medicaid work outside the home (56%). Many others are not employed for pay but are caring for family members (19%), have a serious illness or disability (13%), or attend school (6%). Approximately six in ten mothers on Medicaid (62%) are working and another quarter are caring for

family members. Among women without children, half (53%) are working and another 19% have an illness or disability (**Figure 4**). Some states now condition Medicaid eligibility on meeting work requirements, but most women who qualify for the program already work outside the home or would be exempt because they are caring for family members or have a chronic illness or disability. Even if they are exempt, the reporting requirements associated with Medicaid work requirements can make it more difficult to maintain their Medicaid coverage. For example, one in three Medicaid adults never use a computer or the internet, and four in ten do not use email, which would make compliance with reporting requirements difficult for these groups.

Figure 4

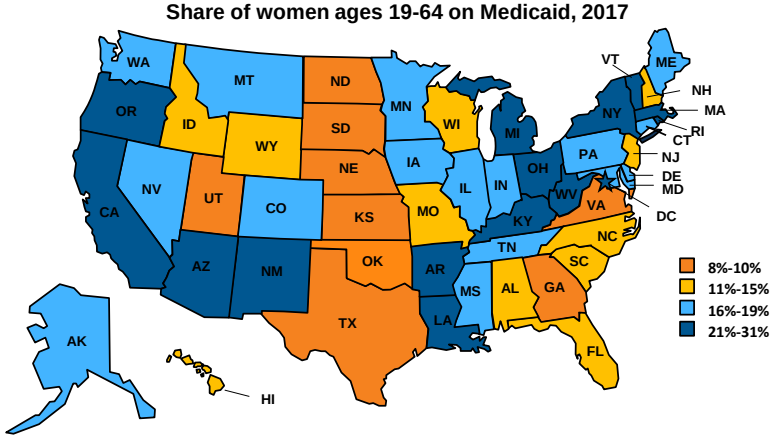
Most Women on Medicaid Work Outside the Home



NOTES: Women ages 19-64 enrolled in Medicaid in 2016. "Other" work status includes retired women and others. Work status is among non-SSI, nonelderly women. Percentages may not add up to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of 2017 ASEC Supplement of the Current Population Survey, U.S. Census Bureau.

Figure 5

Medicaid Coverage Varies Considerably by State



SOURCE: Kaiser Family Foundation. Health Insurance Coverage of Women 19-64, Medicaid 2017. State Health Facts.
Kaiser Family Foundation estimates based on the 2017 Census Bureau's American Community Survey.

- Differences in Medicaid eligibility levels and poverty rates across the states translate into vastly different Medicaid coverage rates for women across states, from lows of 8% in Utah and Virginia to 31% in New Mexico (**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, and pregnancy-related care including prenatal services, childbirth, and postpartum care—all without cost-sharing. Medicaid coverage of abortion services, however, is very limited under federal law and in most states.

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 for private insurance and individuals who qualify as a result of the Medicaid expansion. Research has found that most states have aligned their benefits and 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 for family planning. 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.
- The federal government also guarantees Medicaid beneficiaries "free choice of provider" which allows them to seek care from any qualified participating provider that offers the services. While free choice of provider is not specific to family planning, it means that states cannot bar providers from the Medicaid program simply because they provide abortion services. For beneficiaries enrolled in managed care arrangements, there is a protection that specifically allows them to seek family planning services from the provider of their choice even if the provider is outside of the plan's network.
- The free choice of provider policy has been in the spotlight in recent years as some federal and state policymakers attempt to exclude Planned Parenthood and other clinics that provide both contraception and abortion services from participating in the Medicaid program. Family planning providers that also offer abortion services have successfully challenged these bans in many of the states that have imposed them, but litigation is still ongoing in several states.
- Twenty-five states currently operate limited scope Medicaid family planning programs which extend access to family planning services to uninsured women who do not qualify for full Medicaid coverage because they are not poor enough to qualify for Medicaid or have lost Medicaid eligibility after having a baby.

MATERNITY CARE:

Medicaid is the largest single payer of pregnancy-related services, financing 43% of all U.S. births in 2016. In five states and DC, Medicaid covers more than 60% of all births. 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 which includes a broad range of preventive services for pregnant women. States may not charge cost-sharing for any pregnancy-related services. Overall, most states cover a broad range of

perinatal services across eligibility pathways, including prenatal screenings, folic acid supplements, and breastfeeding supports.

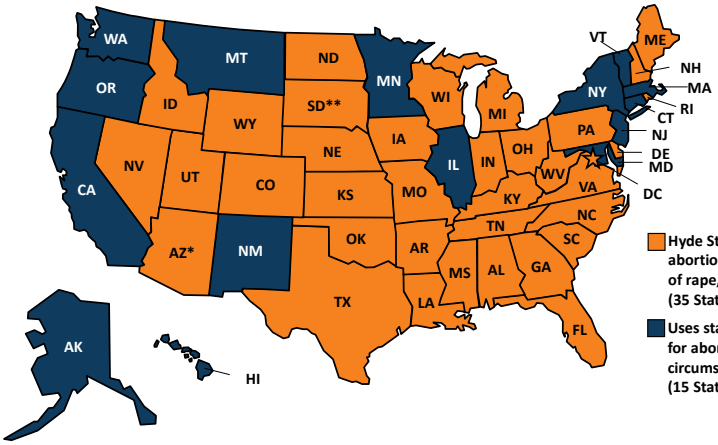
- In the 14 states that have not expanded Medicaid coverage under the ACA, many women lose their Medicaid eligibly 60 days post-partum because they no longer qualify for coverage, even though their infants are Medicaid eligible for their first year. This is because the income eligibility for pregnancy-related care is typically considerably higher than those offered to parents of dependent children. In the states have expanded Medicaid eligibility, most women with Medicaid financed births are now able to remain enrolled in the program and have continuous coverage and better access to care.

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 6**). States may use their own unmatched funds to cover abortions in other circumstances. As of January 2019, 15 states cover abortions for Medicaid beneficiaries that are considered to be "medically necessary" and pay for these using only state funds. A January 2019 U.S. Government Accountability (GAO) report found that 14 states were not covering medication abortions, even when the abortion was eligible for federal funding, in violation of federal law. One state, South Dakota, has not covered abortions in cases of rape or incest for 25 years.

Figure 6

Abortion Coverage is Very Limited Under Medicaid



NOTES: 17 states have policies or are under court order to pay for all or most medically necessary abortions for Medicaid enrollees. 34 states and DC follow Hyde Restrictions. *AZ only provides abortions in cases of life endangerment, rape, and incest in violation of court order. **SD covers abortions only in cases of life endangerment.
SOURCE: Kaiser Family Foundation. Interactive: How State Policies Shape Access to Abortion Coverage. As of January 2019.

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.[2]

- 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. 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

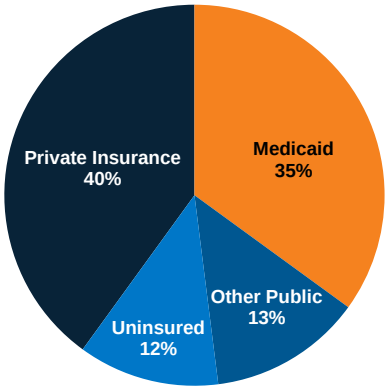
- Under the Breast and Cervical Cancer Prevention and Treatment Act, states may extend Medicaid coverage for cancer treatment to uninsured women diagnosed with breast or cervical cancer through a federal screening program and receive a federal match for those services. In 2013, over 57,000 women were enrolled in Medicaid through the Breast and Cervical Cancer Program.[3]
- 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.

WOMEN WITH DISABILITIES

- Medicaid plays a critical role financing care for women with 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.

Figure 7

Medicaid Covers One-Third of Women with Disabilities



Total = 13.0 million nonelderly adult women with disabilities, 2017

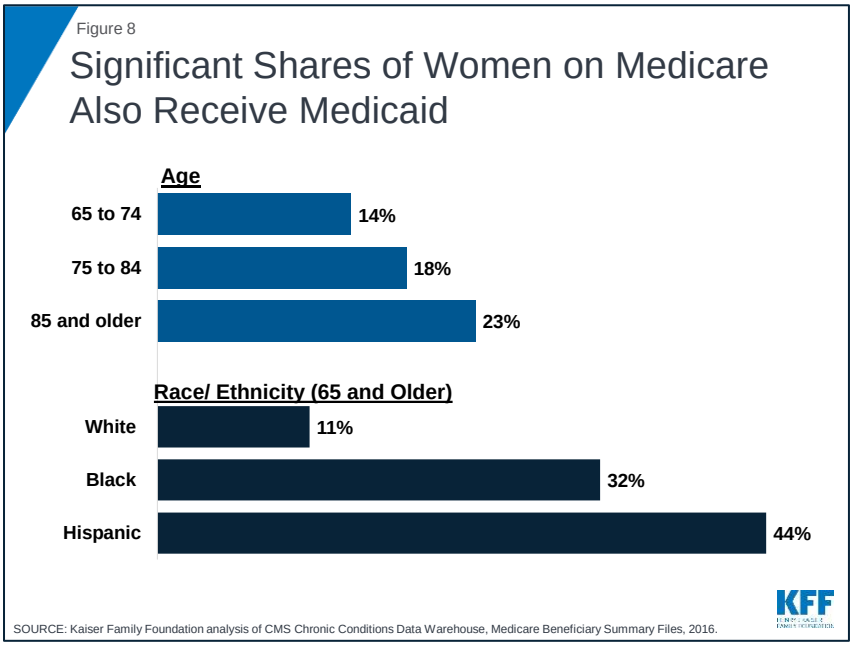
NOTES: Includes adults ages 18-64. Excludes those in long-term care facilities. Disability includes limitation in vision, hearing, mobility, cognitive functioning, self-care, and/or independent living. Other public includes those with Medicare (excludes Part A only), military or Veterans Administration coverage (excludes Tricare), and other government or state-sponsored health plans. Medicaid includes those dually enrolled in Medicare and Medicaid. .
SOURCE: Kaiser Family Foundation analysis of 2017 National Health Interview Survey data.

- Benefits that Medicaid covers include: assistance with medical and supportive services including 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 critical health benefit for women with disabilities that has very limited coverage through commercial plans.
- Medicaid covers more than one in three (35%) nonelderly women with disabilities (**Figure 7**). People with disabilities account for 15% of total Medicaid enrollment but 42% of program spending due to their greater health needs and more intensive service use.

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 and costly health needs, but only those who are very poor or face very high medical costs can qualify.

- There are 11.7 million dual eligibles, and women account for 60% of this group.[4] A significant share of women over the age of 65 who have Medicare coverage also receive Medicaid (**Figure 8).** Dual eligible beneficiaries fall into two groups: Those who qualify for full-scope Medicaid and receive coverage for services that Medicare does not currently cover, such as nursing home stays and dental and vision care, as well as 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 assistance to cover some of Medicare's out-of-pocket costs, such as premiums and cost sharing.



- Medicaid covers a continuum of long-term services and supports ranging from home and community based services (HCBS) that allow persons to live independently in their own homes or in other community settings to institutional care provided in nursing facilities and intermediate care facilities for individuals with intellectual disabilities. In FY2015, HCBS represented 55% of total Medicaid expenditures on long-term services and supports (LTSS).
- 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%) and people receiving home health care (62%) are women. Medicaid coverage gives access to these critical long-term services, which would otherwise be unaffordable for women with fixed incomes (in 2018, nursing home care averaged more than $89,297 annually for a semi-private room).

Access to Care

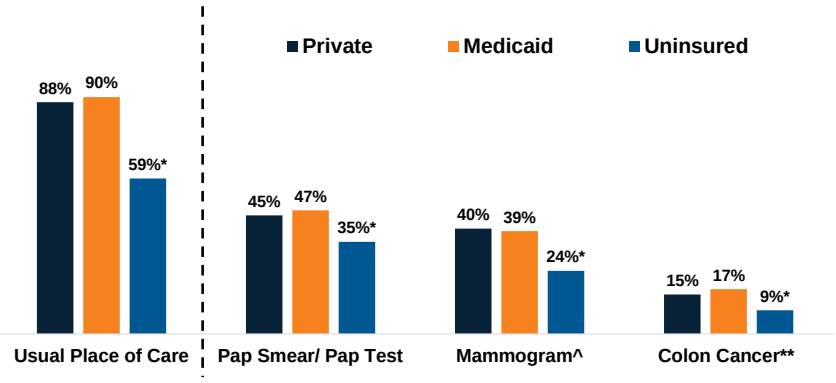
Compared to their uninsured counterparts, women with Medicaid experience fewer barriers to care and on several measures have utilization rates comparable to women with private insurance.

- 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. Compared to low-income women with private insurance, women on Medicaid were less likely to report that they delayed or went without care due to cost, likely attributable to the fact that Medicaid does not charge deductibles, rarely charges premiums and has only nominal cost-sharing. Affordability, however, is still a problem for some women in the program because they are typically poor or very low-income and have pay out of pocket costs in states that impose caps on the number of covered visits or prescriptions or charge copayments for prescription drugs (for non-pregnant adults). One in 10 low-income women on Medicaid report that they had not filled a prescription (11%) in the past year because of the cost (**Figure 10**).

Figure 9

Low-Income Women with Medicaid Use Preventive Care at Similar Rates to those with Private Coverage

Percent of low- income women reporting they received screening test in the prior 12 months, 2017

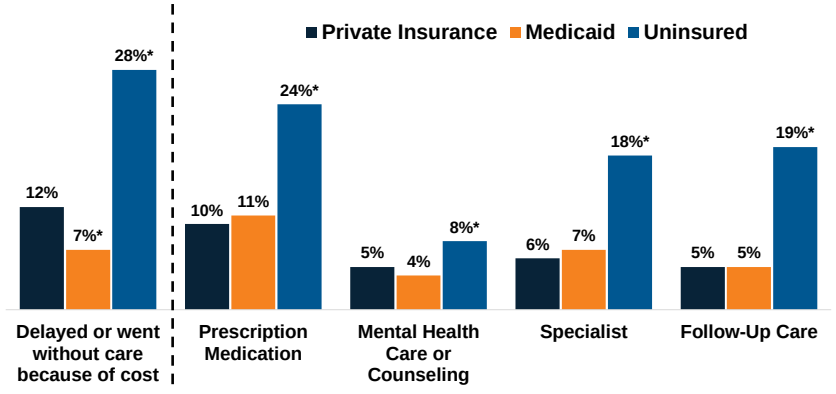


NOTES: Among low-income women 18-64. Low-income includes women living at or below 200% the Federal Poverty Level (FPL) which was $24,120 for an Individual in 2017. ^Among women 30+. **Among women 40+. *Indicates a statistically significant difference from private insurance; p<.05.
SOURCE: Kaiser Family Foundation analysis of 2017 National Health Interview Survey

Figure 10

Few Low-Income Women with Medicaid Experience Cost Barriers

Percent of low income women who did not get care they needed because of cost, 2017



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SOURCE: Kaiser Family Foundation analysis of 2017 National Health Interview Survey.

Endnotes

[1] 138% Federal Poverty Level in 2016 was $16,394 per year for individuals.

[2] Kaiser Family Foundation analysis of National Survey on Drug Use and Health, 2015.

[3] Kaiser Family Foundation estimates based on the Medicaid Statistical Information System (MSIS) data from FY2013-FY2015.

[4] Kaiser Family Foundation analysis of the Chronic Conditions Data Warehouse 5 percent sample of Medicare claims for 2016.