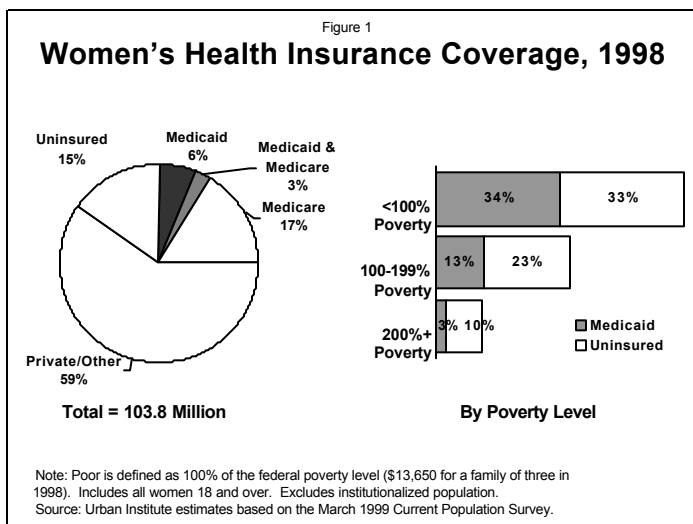


November 2000

MEDICAID'S ROLE FOR WOMEN

Medicaid, the nation's health insurance program for the poor, provides over 12 million low-income women with basic health and long-term care coverage. Medicaid makes a critical difference for these women by improving their access to care. Women are more likely to qualify for Medicaid than men because women tend to be poorer and meet Medicaid's restrictive categorical criteria—70% of Medicaid beneficiaries ages 15 and older are women. In 1998, 9% of women were covered by Medicaid. For low-income women, Medicaid's role is even more striking; it provides coverage for one-third of poor women and 13% of near-poor women (Figure 1).



ELIGIBILITY

The major Medicaid eligibility pathways for adult women are:

Parents in Families with Dependent Children: Eligibility is generally limited to adults with children. States can use 1996 Aid to Families with Dependent Children (AFDC) standards to determine eligibility or use higher income levels. While the majority of states use the AFDC-related standards which range from 15% of the Federal Poverty Level (FPL) in Alabama through 81% FPL in Connecticut, 18 states now have adopted plans to extend eligibility to all families below poverty.

Pregnancy: Pregnant women with incomes up to 133% of poverty are covered in all states up to 60 days postpartum. Women with incomes up to 185% of poverty or higher can be covered at state option (37 states and DC expand eligibility beyond 133%).

Transitional Medicaid: States are required to provide at least six months of transitional Medicaid assistance (TMA) to families who lose welfare benefits due to an earnings increase. Participation in TMA has been limited.

Disability: Women with disabilities typically qualify for Medicaid by meeting Supplemental Security Income (SSI) requirements. At state option, others can qualify if their medical expenses cause them to impoverish themselves or spend down to a state's medically needy income standard.

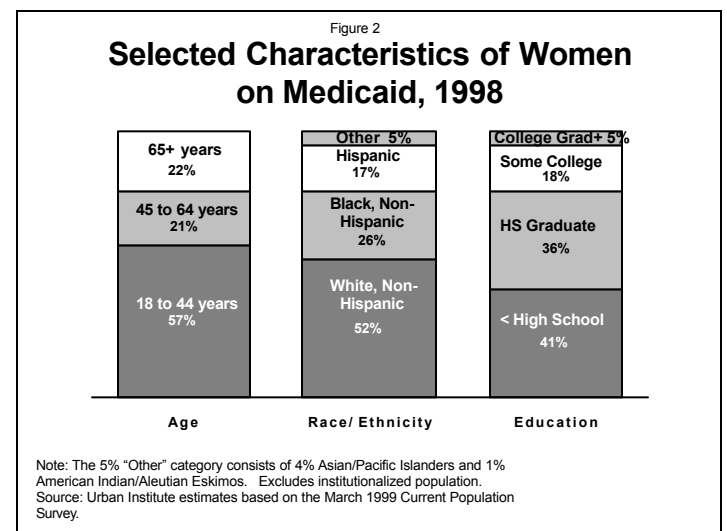
Medicare Beneficiaries: Elderly women with Medicare coverage and who also qualify for SSI can receive full Medicaid benefits,

such as prescription drugs and long-term care, as well as assistance with Medicare cost-sharing and deductibles. For other low-income Medicare beneficiaries, Medicaid pays for some Medicare cost-sharing and deductibles, depending on their incomes.

Nursing Home Residents: Medicaid provides nursing home coverage to those who qualify on the basis of SSI. In addition, in 35 states and DC, people may become eligible for Medicaid benefits if they impoverish themselves with nursing home costs.

WHO ARE THE WOMEN ASSISTED BY MEDICAID?

Because Medicaid is means-tested and generally is targeted at women who are pregnant, have children, or have health problems, women with Medicaid are more likely than the total female population to be poor, minorities, of reproductive age, and less educated (Figure 2). They are also more likely to be single parents, in poorer health, and have conditions that limit their ability to work.



BENEFITS

Medicaid pays for a broad range of services for women, including inpatient and outpatient hospital care, physician, midwife, certified nurse practitioner services, laboratory and X-ray. Other Medicaid services of particular importance to women include:

Prenatal Care and Delivery: Medicaid pays for prenatal visits, delivery, and other pregnancy-related care, as well as postpartum care. Medicaid finances over one-third of all US births.

Preventive Services: Medicaid routinely covers screening, such as mammograms, pap smears, and STD testing and treatment.

Family Planning: States receive 90 cents from the federal government for every 10 cents they spend on family planning, a higher rate than for other services. Twelve states have special Medicaid programs to pay family planning costs for low-income women who are ineligible for full Medicaid assistance.

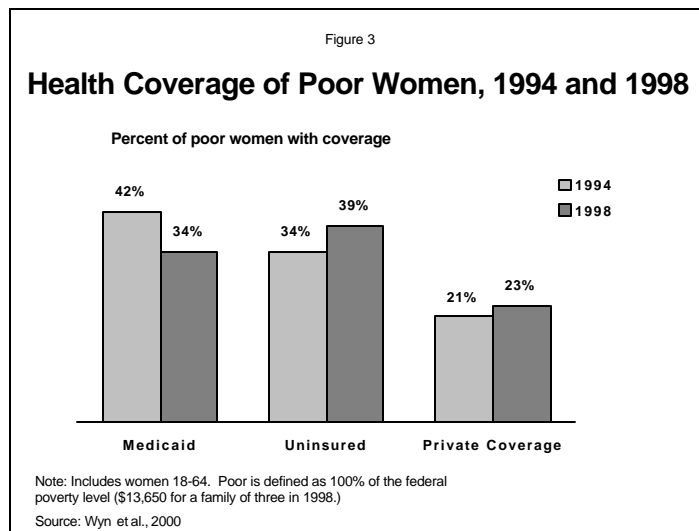
Abortion: Federal Medicaid dollars can only pay for abortions in cases of rape, incest, or when the woman's life is in danger. Sixteen states choose to fund other "medically necessary" abortions sought by women using only state or local funds.

Long-term Care: Medicaid finances the care of nearly 70% of nursing-home residents in the US, three-fourths of whom are women. Medicaid also covers home- and community-based long-term care services, but coverage is often limited to a certain region of the state or to certain groups.

Prescription Drugs: An optional benefit, virtually all states cover outpatient prescription drugs with nominal or no copayments.

KEY ISSUES FOR WOMEN

Enrollment. Medicaid enrollment among low-income women has fallen. Medicaid coverage of poor women has decreased and the share of uninsured has risen (Figure 3). The reduction between 1994 and 1998 is attributable largely to changes in Medicaid eligibility policy that occurred when the 1996 welfare law severed the automatic link between Medicaid and cash assistance. An Urban Institute study found that one year after losing welfare assistance, 22% of women still had Medicaid, but 49% were uninsured (Garrett and Holahan, 2000). Many women who leave welfare work in low-wage jobs that lack benefits such as health insurance.



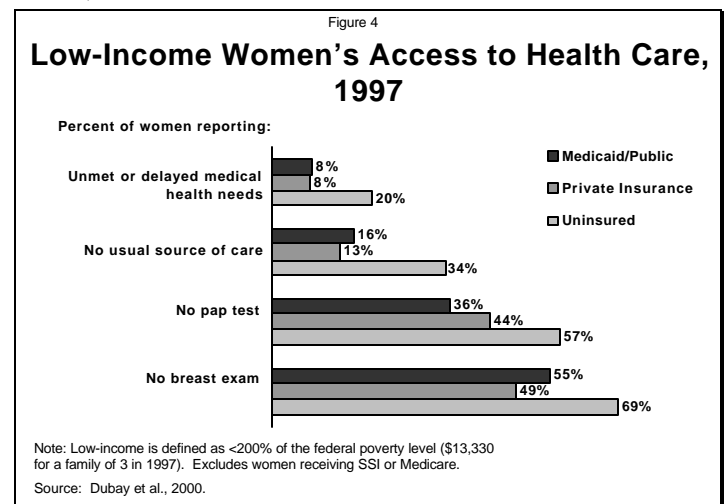
Women who apply for welfare assistance may qualify for Medicaid, but are sometimes sent to find work or other sources of financial assistance before they can apply. Although women leaving welfare may be eligible for Transitional Medicaid, many do not know about it or do not understand that they may qualify. To improve enrollment, some states have expanded income eligibility standards and simplified the enrollment process. However, unless women have children, are pregnant, are over 65, or become disabled, they are generally not eligible for Medicaid – no matter how poor.

Access to Care and Managed Care. For the millions of women on Medicaid, having coverage makes a critical difference in their access to care. Compared to their uninsured counterparts, women on Medicaid experience fewer barriers to care (Figure 4). Medicaid managed care has been used as a strategy to improve access for beneficiaries, although the results have been mixed. In 1999, over half of the Medicaid population (56%)—mostly low-income women and their children—was enrolled in managed care. Research shows that women in Medicaid managed care are more likely to have a regular source of care than low-income women in Medicaid fee-for-service. Despite managed care's potential to improve preventive care, women in Medicaid managed care are no more likely than women in Medicaid fee-for-service to receive services, such as breast exams and pap tests. However, there is also evidence that women in Medicaid managed care may experience more problems with access to and satisfaction with their care.

Reproductive Health. The majority of women on Medicaid are in their prime childbearing years (18-44). For them, access to contraceptive services, STD testing and treatment, perinatal health care, and other reproductive services are of critical importance. Yet access to reproductive health services for women in Medicaid can be problematic. Women enrolled in Medicaid managed care may not know they can go out-of-plan to obtain their family planning care with any Medicaid participating provider (referred to as “freedom of choice”) or may be enrolled in a plan that does not provide family planning referral or counseling. Additionally, federal funding of abortions is very restricted and most states will only cover abortion services in limited circumstances. This can hinder access for women with Medicaid, since such services can be unaffordable for those with low-incomes.

Medicaid plays a critical role in financing prenatal care and delivery. However, some women still have problems finding providers since many office-based ob/gyns do not participate in Medicaid or are not located in communities where beneficiaries live. Furthermore, Medicaid coverage for pregnant women ends 60 days postpartum. If the mother does not qualify through another eligibility pathway, she loses her coverage, even though her infant is covered for a full year.

Long-term Care. Since women live longer and experience higher rates of chronic illness and disability in old age than men, they are more likely to rely on long-term care services. Over 70% of nursing home residents and two-thirds of people receiving home health care are women. This care can have devastating economic consequences—a year in a nursing home can cost families \$50,000 or more. Medicaid is vitally important for many of these women—but only those who are very poor or face catastrophic costs can qualify. Access to long-term care services is further complicated by the limited availability of nursing home beds for Medicaid beneficiaries. Community-based alternatives have also been limited under Medicaid—less than 20% of Medicaid long-term care spending is for home and community based care, personal care, and home health services. Much of this care is provided informally by family and friends, often women.



Medicaid improves access to health and long-term care for low-income women. It is a vital source of coverage for millions of women who do not have insurance through their employers or who lack the resources to purchase their own coverage. Effective outreach and enrollment strategies, coupled with state and federal eligibility expansions, will be necessary if we are to broaden Medicaid's reach to the 8.5 million uninsured low-income women who still need assistance.