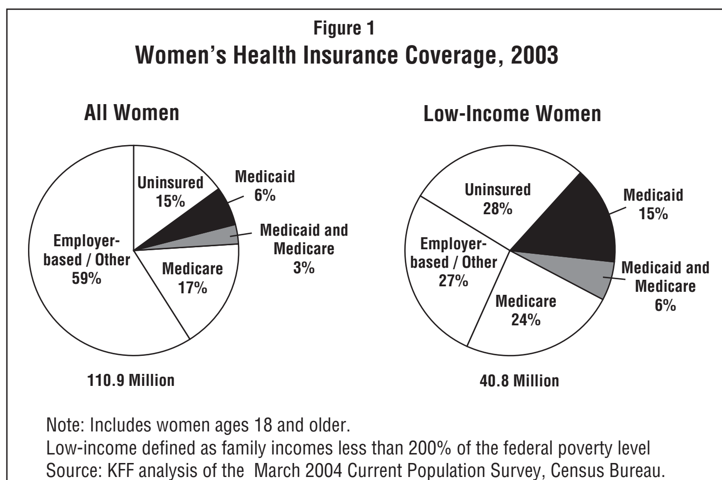
WOMEN'S ISSUE BRIEF
AN UPDATE ON WOMEN'S HEALTH POLICY
THE HENRY J. KAISER FAMILY FOUNDATION

MEDICAID'S ROLE FOR WOMEN

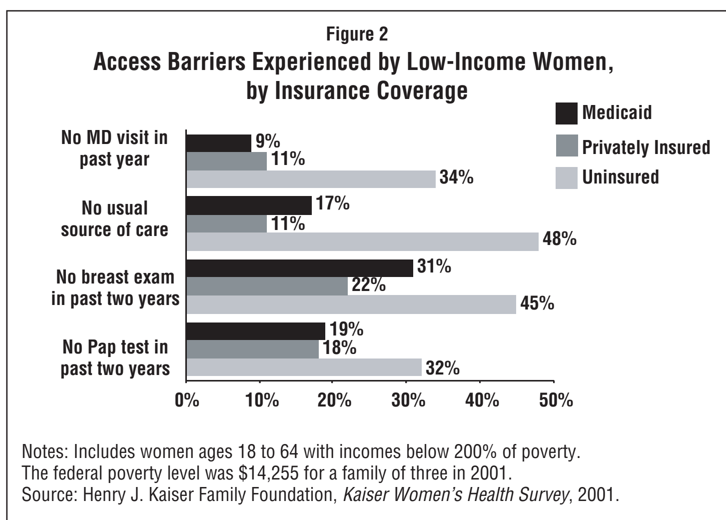
November 2004

Medicaid, the state-federal health coverage program for the low-income population, provides over 16 million low-income women with basic health and long-term care coverage.[1] While often not viewed as a women's health program, Medicaid covers a wide range of health services that are important to women throughout their lives, including reproductive health care, ongoing care for chronic conditions and disabilities, and long-term care.

In 2003, overall, one in ten (9%) women were covered by Medicaid, and among low-income women, one in five (21%) were covered (Figure 1).[2] Women comprise the majority (71%) of adult beneficiaries because they are more likely than men to qualify for the program as the parents of dependent children or with longer life spans to qualify for coverage in their older years.

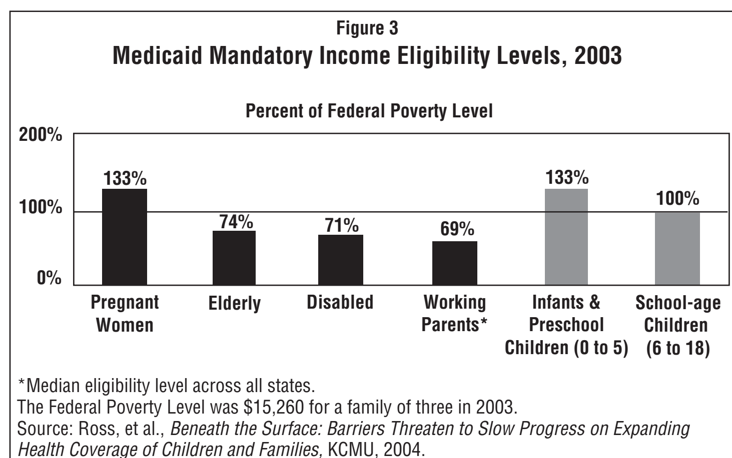


A large and growing body of evidence has shown that having insurance coverage makes a critical difference in accessing health care, and Medicaid has been shown to improve access for low-income women.[3] Compared to their uninsured counterparts, low-income women on Medicaid experience fewer barriers to care and have utilization rates comparable to women with private coverage (Figure 2).



WHO IS ELIGIBLE?

In order to qualify for Medicaid, women must meet both categorical and income criteria. That means that one must fit into a certain "category" such as being pregnant, a mother of a child under 18, 65 or older, or having a disability. Each of these different groups has different income elibiligy criteria, which also vary from state to state (Figure 3).



In most states, the income eligibility levels for adults are at or below the poverty level. Because women are more likely than men to meet these criteria (because they fall into one of the categories and because they are more likely to be low-income), women are more likely to qualify for Medicaid assistance. Many very low-income women, however, do not qualify for Medicaid, no matter how poor they are, because they do not have children under 18 and are not over age 65.

The major Medicaid eligibility categories for adult women are:

Pregnant Women: States must extend eligibility for pregnancy-related services to pregnant women with incomes up to 133% of the federal poverty level (FPL), ($11,944 for an individual in 2003), during the pregnancy and up to 60 days postpartum. States can receive federal matching funds for coverage of pregnant women with incomes up to and beyond 185% FPL. In general, immigrants are banned from Medicaid coverage for the first five years in the U.S., but states can cover women at their own option without federal funds.

Parents with Dependent Children: This group was originally limited to adults who were receiving welfare cash assistance. Today, states can use 1996 welfare income standards to determine eligibility; however, some states have extended coverage to parents beyond these very low thresholds. As of July 2004, income eligibility levels for working parents ranged from 19% FPL in Alabama to 275% FPL in Connecticut.[4]

Seniors and People with Medicare: Low-income Medicare beneficiaries who qualify for Supplemental Security Income (SSI) cash assistance can receive full Medicaid benefits as well as assistance with Medicare cost-sharing. Other low-income seniors who are not poor enough to qualify for SSI can receive some assistance with Medicare cost-sharing and deductibles, but don't have coverage for prescription drugs or long-term care. States can cover people above SSI levels at their own option.

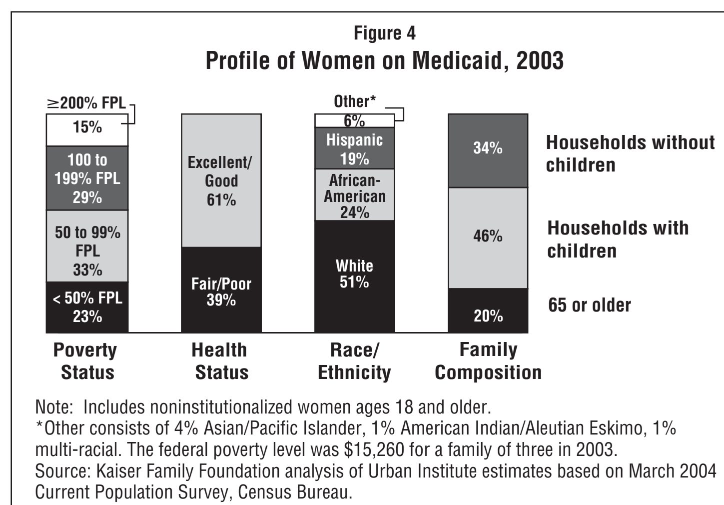
People with Disabilities: Women under age 65 with disabilities who qualify for SSI typically also qualify for Medicaid even if they don't have Medicare.

Medically Needy: At state option, eligibility can be extended to others if they "spend down" their assets to meet their state's low income threshold or if their medical expenses are so high that they meet their state's "medically needy" income standard.

Profile of Women Assisted by Medicaid

In 2001, nearly three-quarters (71%) of adults (age 19 and older) on Medicaid were women.[5] This diverse group of women faces many social and economic challenges that affect their ability to receive timely and quality health care. Women with Medicaid are more likely than the total population to be of reproductive age, poor, minorities, less educated, and parents (Figure 4).

- Nearly six in ten (56%) women on Medicaid who live in the community have family incomes below the poverty level. Almost one-quarter (23%) of women have incomes below 50% of the poverty level, about $7,500/ per year.
- Half (46%) of women on Medicaid are living with children in the household.
- Four in ten (39%) women on Medicaid report fair or poor health, three times the rate of women with private coverage or Medicare (13%) or women who are uninsured (12%).

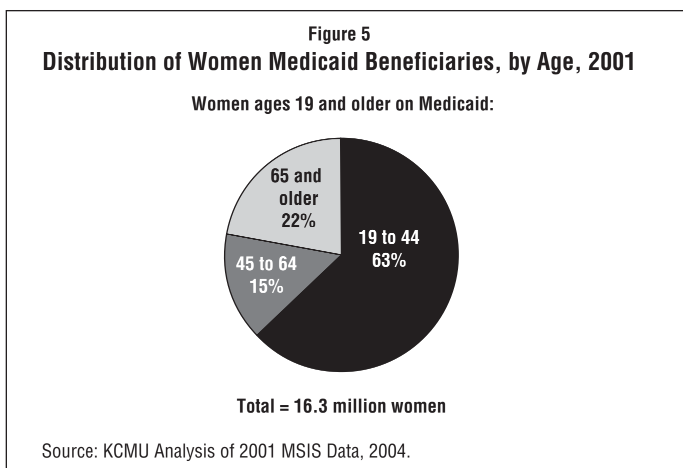


Medicaid and Women's Health Across the Lifespan

Medicaid's benefit package pays for a broad range of services important to women across the different stages of their lives. This includes inpatient and outpatient hospital services, physician services, lab and x-ray services, preventive and screening care, family planning, prenatal care, prescription drugs, and long-term care.

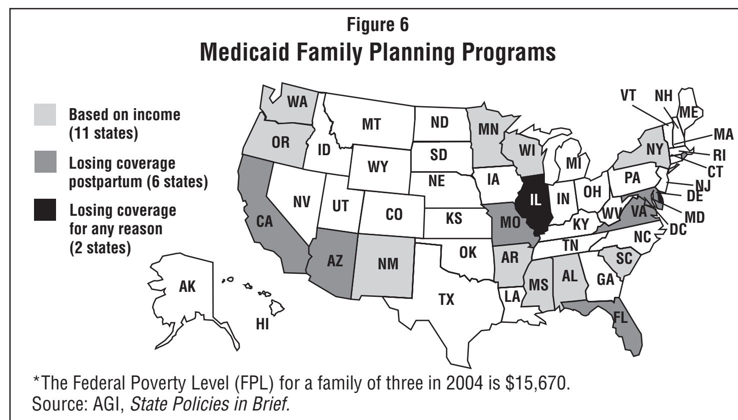
Reproductive Years

Nearly two-thirds (63%) of women on Medicaid are in their reproductive years (19 to 44) (Figure 5). For these women, Medicaid covers a wide range of important services, including family planning, STD testing and treatment, screenings such as pap smears, and pregnancy-related care, (including prenatal services, childbirth, and postpartum care). Medicaid coverage of abortion services, however, is very limited.



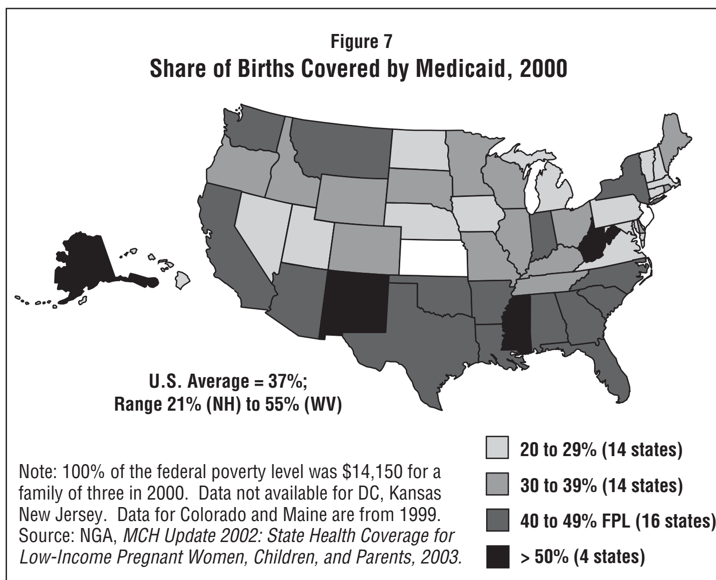
Family Planning: Recognizing the growing problem of unintended pregnancies in the 1970s, family planning was one of the services explicitly mandated for coverage by federal Medicaid law. To encourage the provision of family planning services, the federal government provides states an enhanced match of 90 cents for every 10 cents they spend on family planning, higher than for other services (typically matched at a rate between 50% and 77%). States can claim this enhanced match for services and supplies that "are expected to achieve a family planning purpose."

- Under this broad guideline, states routinely cover preventive services and screenings such as prescription contraceptives, pap smears, STD testing and treatment, and counseling as part of the family planning benefit.
- Medicaid is the largest source (over half) of public funding for family planning services, reaching $770 million in 2001. Family planning expenditures have kept pace with overall Medicaid spending, rising about 75% between 1995 and 2001, but this is only half the rate of increase for overall Medicaid prescription drug expenditures.[6]
- Family planning services and supplies are exempt from cost-sharing, unlike most other medical services covered by Medicaid. This means women cannot be charged any out-of-pocket costs for these services.
- In recent years, states have developed special Medicaid programs to expand Medicaid coverage for family planning services to women who otherwise do not qualify for the program, including low-income women who are not poor enough to qualify for Medicaid and women who have lost Medicaid coverage. Nineteen states have received permission from the federal government to expand family planning coverage using these programs (Figure 6). In 2001, these programs served 1.7 million women, and recent studies have documented cost savings, reductions in unintended pregnancies, and improved use of family planning services in states with these programs.[7]



Prenatal Care and Delivery: Responding to greater attention on rising infant mortality and maternal health, Medicaid eligibility levels were expanded in the late 1980s and 1990s to improve access to prenatal care for low-income pregnant women. Today, Medicaid is one of the largest payers of pregnancy-related services, financing over one-third (37%) of all births in the U.S, and in some states, covering more than half of all births (AK, NM, WV and MS) (Figure 7).

In most states, Medicaid pays for prenatal visits and supplies such as prenatal vitamins, tests such as ultrasound and amniocentesis, and delivery services, including vaginal and cesarean deliveries. Medicaid also covers postpartum care for 60 days, after which the infant is guaranteed coverage for one year, but the mother is not. Coverage for other services, such as nutrition counseling, breastfeeding support, transportation services, smoking cessation, and substance abuse treatment are more limited.[8]



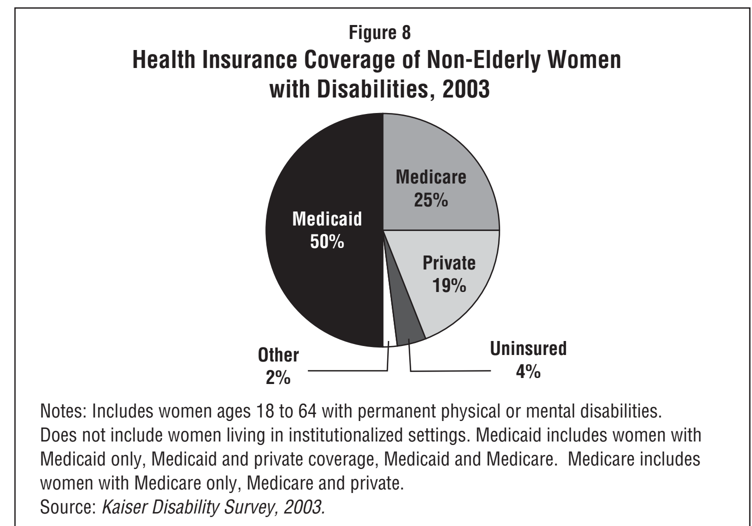
Abortion: Medicaid coverage for abortions is very restricted in most states. The federal Hyde Amendment prohibits federal spending on abortions, except in cases of rape, incest, or when the woman's life is in danger. The Amendment does not make an exception for the health of the woman. Seventeen states choose to use only state funds to provide coverage under very limited circumstances for other "medically necessary" abortions.[9]

Mid-Life Years

As women age, they experience a higher rate of chronic illnesses and disabilities, and are more likely to report fair or poor health status. Risk for a host of conditions, such as arthritis, hypertension, depression, and diabetes increases with age. Thus, women's health needs shift from reproductive care to greater need for screening and treatment of chronic diseases, mental health care, and disability care (although many women in their reproductive years also have these health needs).

Women with Disabilities: Medicaid plays a critical role financing care for women with disabilities, providing assistance with a broad range of medical and supportive services. These women have severe physical and mental disabilities, including physical impairments, severe mental illnesses, and specific conditions such as muscular dystrophy, cystic fibrosis, and HIV/AIDS.[10] Half of non-elderly women with permanent mental or physical disabilities have Medicaid coverage (Figure 8).

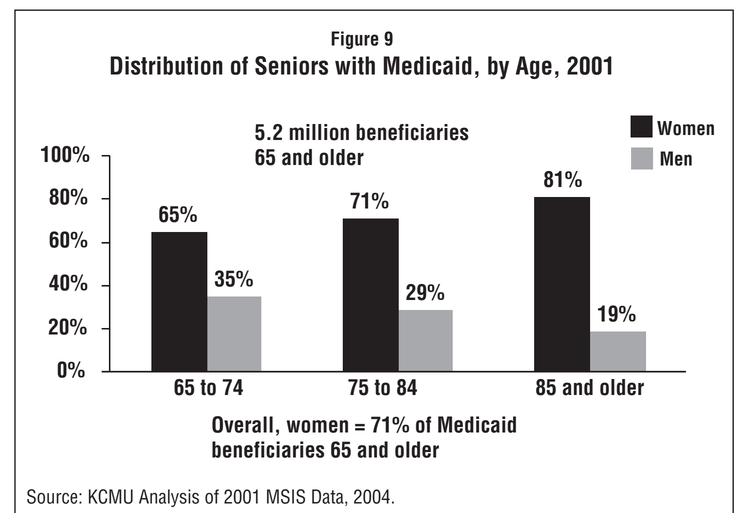
Most people with disabilities on Medicaid qualify because they receive Supplemental Security Income (SSI). These individuals qualify because they are deemed to have a disability that is so severe that they cannot participate in any "substantial gainful activity." Among the benefits that Medicaid covers for women with disabilities are rehabilitation, transportation, and therapeutic services, which help people with disabilities be more self-sufficient and many of which are not covered in private health insurance plans. Long-term care, including home health care is another major health benefit for women with disabilities.



Breast and Cervical Cancer Treatment: In 2000, Congress passed a landmark law in Medicaid's history that allowed states to extend Medicaid coverage to uninsured women with breast or cervical cancer. This law built on a CDC program that offered breast and cervical cancer screening services to low-income and uninsured women, but did not extend coverage for treatment to women once they had received a cancer diagnosis. This optional program has been adopted by all the states, although there is considerable variation from state to state in how the program is operated.

Seniors

For over 3 million low-income elderly women, Medicaid pays for their Medicare cost-sharing, prescription drugs, and long-term care services. Only elderly women who are poor or face catastrophic medical costs can qualify. Women comprise the majority (71%) of seniors on Medicaid overall and in every age group because they live longer and are disproportionately poorer than men (Figure 9).



Medicare Beneficiaries: Medicare beneficiaries who have incomes low enough to qualify for SSI cash assistance are eligible for full Medicaid benefits and are often referred to as "dual eligibles" because they receive both Medicaid and Medicare coverage. Women who qualify as dual eligibles tend to have extensive health needs, face limitations in daily activities, and are very poor. Medicaid currently provides them with coverage for prescription drugs and long-term care services such as nursing home stays and home health care, which Medicare does not currently cover, as well as assistance with Medicare cost-sharing and deductibles.

For low-income Medicare beneficiaries whose incomes exceed the SSI threshold (74% of the poverty level), Medicaid's assistance is more limited. Although some states extend coverage to some seniors with incomes up to 100% of poverty, in most states, seniors with incomes between 74% and 120% of the poverty level (known as Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries) receive limited Medicaid assistance with Medicare premiums and some of Medicare's cost-sharing requirements. These women do not receive Medicaid coverage for long-term care nor prescription drugs.

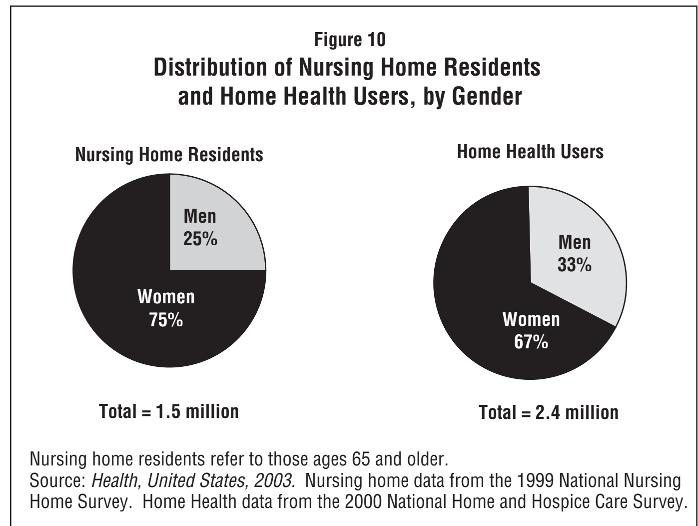
Long-term Care: Since women live longer and experience higher rates of chronic illness and disability than men, they are more likely to require long-term care services in their lifetime. Over 70% of nursing home residents and two-thirds of people receiving home health care are women (Figure 10). This care can be extremely costly—a year in a nursing home can cost families $50,000 or more—and have devastating economic consequences for women on fixed incomes.

Medicaid is the major payer of long-term care in the U.S., financing the care of nearly 70% of nursing home residents in the U.S., in part because Medicare does not provide long-term care coverage and there is very little coverage in the private market as well. Because of their health needs, long-term care accounts for the majority of spending on the dual eligibles. Medicaid also covers home- and community-based long-term care services, but coverage for this type of care has been limited.[11]

Prescription Drugs: Many elderly women on Medicaid rely on costly prescription drugs. Currently, there is no or nominal cost-sharing for prescriptions under Medicaid. For dual eligibles, the passage of the Medicare drug benefit may have notable consequences. The law will shift drug coverage for these seniors from Medicaid to the new Medicare Part D program. The new law also has several provisions, including plan-specific formularies, premiums, and cost-sharing that could impede access to needed medications.

Figure 10

Distribution of Nursing Home Residents and Home Health Users, by Gender



Nursing home residents refer to those ages 65 and older.
Source: *Health, United States, 2003.* Nursing home data from the 1999 National Nursing Home Survey. Home Health data from the 2000 National Home and Hospice Care Survey.

Conclusion

Over 16 million women rely on Medicaid to get the health care they need. In the coming years, state and federal officials will be looking closely at Medicaid, exploring options for containing costs in a program that is often the second largest in state budgets. In the past, Medicaid has been used a vehicle to extend coverage to poor and low-income women, mostly mothers, and to provide supports to seniors and people with disabilities who lack resources to purchase the care they need or to fill Medicare's gaps or pay for long-term care. At a time of limited resources, preserving coverage for some of the most vulnerable women in society and addressing the coverage needs of those who are uninsured and outside the reach of the Medicaid's safety net will be among our most difficult challenges.

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