III. MEDICAID

Medicaid is the national health insurance program for low-income people. The program is jointly run by the federal and state governments; each state administers its own Medicaid program under federal guidelines and the federal government contributes a share of the program's costs.[64] Medicaid covers more than 40 million low-income people, making it one of the largest sources of funding for health care in the U.S. Eligibility is based on both meeting categorical and financial requirements.[65]

Women comprise nearly 70% of the Medicaid population over the age of 15.[66] While Medicaid provides health care coverage for a substantial number of low-income women, its income and categorical eligibility requirements are narrow, generally requiring adults to be pregnant, or low-income and parents of dependent children, or low-income and over age 65, or to have a disability. Because women are poorer than men and are more likely to care for children, they are twice as likely to qualify for Medicaid.[67] Nevertheless, many women, particularly those in low-wage jobs, do not qualify for Medicaid because of its narrow eligibility criteria, yet cannot afford private insurance premiums, leaving 19% of all women ages 18 to 64 and 34% of women living below the poverty level uninsured.[68]

States decide within federal guidelines what populations will be covered by Medicaid and which benefits beyond those mandated by the federal government will be provided. Certain populations such as low-income children and pregnant women and some seniors and people with disabilities must be covered by every state participating, as must certain services, including hospital and physician services, prenatal care, childhood vaccinations, family planning services and supplies, and nurse-midwife services.[69]

Despite restrictive eligibility criteria, Medicaid plays a critical role in securing access to care for its beneficiaries, with an emphasis on many services that are important to women. Medicaid covers about 8% of women ages 18 to 64, a total of more than 8.8 million women nationwide.[70] Medicaid is the largest insurer of single mothers, covering almost 40% of this population.[71] Medicaid is also the largest source of financing for publicly-funded family planning programs, providing approximately half of all public funding.[72] Nearly a quarter of women who use reversible methods of contraception obtain family planning services from a clinic or a private doctor reimbursed by Medicaid.[73] Furthermore, because of a federal mandate that states must cover pregnant women with incomes at or below 133% of the FPL, Medicaid finances one-third of all births in the U.S.[74]

Medicaid also plays an important role for seniors and qualified people with disabilities. Medicare lacks coverage for several important services, notably long-term care and prescription drugs, leaving many beneficiaries with large out-of-pocket costs.[75] Not only are women greater users of these services, but cost-sharing requirements have a greater effect on women than on men, as they are poorer, live longer, have more chronic health conditions, and make up the vast majority of Medicare beneficiaries over the age of 75.[76]

While the majority of Medicaid beneficiaries are children and adults in low-income families, nearly 70% of Medicaid spending goes to services for people with disabilities and people age 65 and older.[77]

In an effort to control deductibles and premiums as well as the cost of providing health care services and improve the continuity of care for the poor, most states now require all or some Medicaid beneficiaries to enroll in managed care. The majority of adult female Medicaid beneficiaries are now enrolled in managed care, which raises important questions about access to family planning and other services under managed care networks, particularly for women enrolled in faith-based plans. Medicaid has also been used to selectively cover services such as family planning or breast and cervical cancers for women without health coverage.

This chapter examines state Medicaid policies that influence low-income women's access to health services, including eligibility levels, mandatory Medicaid managed care programs, and expansions of Medicaid coverage for specific services.

MEDICAID ELIGIBILITY

Income is one of the most important criteria for Medicaid eligibility for qualifying populations, with most states establishing thresholds below 100% of the FPL. However, certain groups of people, designated by the federal government as "categorically needy" populations, must be covered by every state participating in the Medicaid program as follows:[78]

- Individuals who meet the income and resource eligibility requirements for their state's welfare program prior to the implementation of the 1996 welfare reform law;
- Pregnant women and children under age 6 in families with incomes at or below 133% FPL;
- Children under the age of 19 in families with incomes below 100% of the FPL;
- Certain groups of low-income seniors and people with disabilities.

States have several avenues for extending eligibility beyond these minimum federal requirements. Without federal permission, states can elect to raise income eligibility thresholds or disregard a portion of applicants' earnings or assets. In order to extend health benefits to more uninsured people or to categorically eligible populations at higher income levels, states may apply to the federal government for a variety of federal waivers from statutory and regulatory requirements. The basis of these expansions may be a particular health service or a particular population. For instance, states may use waivers to expand family planning services to populations not ordinarily covered under Medicaid, such as adults without children. Waivers have become an important tool which states can use to broaden Medicaid eligibility.

Parents of Dependent Children

Section 1931 Family Coverage

The welfare reform law of 1996 fundamentally changed Medicaid by delinking eligibility for Medicaid from eligibility for welfare cash assistance. However, in order to provide health coverage to people leaving the welfare rolls and entering the job market, Congress established the Transitional Medical Assistance (TMA) program. Individuals who obtained jobs and consequently were no longer eligible for cash assistance yet did not obtain employer-sponsored health insurance were permitted to retain Medicaid coverage for a limited period of time in the form of TMA. Furthermore, states were given new flexibility to extend Medicaid coverage to several groups of low-income parents who had not previously been eligible for Medicaid. States now have the opportunity to expand Medicaid coverage to the parents of low-income children through Section 1931 family coverage.[79]

Section 1931 of the Social Security Act requires states to cover families with incomes below the welfare qualifying income threshold that was in effect in July 1996 for their respective state.[80] States are allowed and encouraged to expand coverage to parents with higher incomes within limits set by the federal government. Most states and the District of Columbia have opted to expand Section 1931 coverage for either unemployed or employed parents of dependent children, although the income thresholds of the expansions vary and tend to be higher for working families. The majority of coverage expansions for unemployed parents cover those in families with incomes up to 50% of the FPL ($5,805 for a family of two in 2001), while the majority of coverage expansions for working parents cover those with incomes between 50% and 100% of the FPL ($11,610 for a family of two in 2001). States often disregard a portion of employed parents' earnings, hence expanding eligibility for these working parents. This is another example of the flexibility states can employ to expand Medicaid eligibility.

TABLE III-1 SECTION 1931 COVERAGE EXPANSIONS FOR PARENTS

- 41 states and the District of Columbia provide Medicaid coverage to low-income parents through Section 1931 family coverage.
  - 30 states extend Medicaid eligibility to unemployed parents in families with incomes up to 50% of the FPL; 13 states extend eligibility to employed parents in families with incomes up to 50% of the FPL.
  - 8 states extend eligibility to unemployed parents in families with incomes between 51% and 100% of the FPL; 22 states extend eligibility to employed parents in families with incomes between 51% and 100% of the FPL.
  - 2 states extend eligibility to unemployed parents in families with incomes between 101% and 199% of the FPL; 5 states extend eligibility to employed parents in families with incomes between 101% and 199% of the FPL.
  - One state, Washington, and the District of Columbia cover unemployed and employed parents in families with incomes at 200% of the FPL.

Section 1115 Waivers to Broaden Eligibility

Prior to the 1996 welfare reform law, states' primary option for expanding Medicaid eligibility to low-income parents was through a Section 1115 research and demonstration waiver.[81] States can apply to the federal Department of Health and Human Services for permission to alter their Medicaid program from the statutory requirements to test new approaches to delivering services or expand coverage to additional populations. The waivers have to meet rigorous regulatory review and have to be budget neutral. Under the terms of the 1115 waivers, states can provide expansion populations with a benefits package that is less generous than standard Medicaid benefits and require cost-sharing on the part of enrollees in the form of copayments or premiums.[82]

Nine states have gained federal permission to expand Medicaid coverage to parents using 1115 waiver authority. The income eligibility levels for 1115 waiver expansions tend to be higher than the levels set under Section 1931 family coverage. All of the nine states are covering populations at or above 100% of the FPL.

TABLE III-1 SECTION 1115 WAIVER COVER AGE EXPANSIONS FOR PARENTS

- 9 states provide Medicaid coverage to low-income parents through Section 1115 waivers.
  - 4 states offer eligibility to unemployed and employed parents in families with incomes between 100% and 133% of the FPL.
  - 3 states extend eligibility to unemployed and working parents in families with incomes between 185% and 200% of the FPL; 1 state, New Jersey, extends eligibility to unemployed parents up to 200% of the FPL, but offers coverage to working parents only between 25 and 37% of the FPL.
  - Minnesota offers the most generous coverage up to 275% of the FPL for employed and unemployed parents.

TABLE III-1
Section 1931 and 1115 Waiver Coverage Expansions for Parents

	Unemployed Parents		Employed Parents	
State	Income Eligibility Limit ($ per month)*	Income Eligibility Limit (% FPL)	Income Eligibility Limit ($ per month)	Income Eligibility Limit (% FPL)
Alabama	164	13	254	21
Alaska	1,118	73	1,208	79
Arizona ~	1,219	100	1,309	107
Arkansas	204	17	255	21
California	1,219	100	1,309	107
Colorado	421	35	511	42
Connecticut	1,829	100	1,919	100
Delaware	1,219	100	1,491	122
District of Columbia	2,438	200	2,438	200
Florida	303	25	806	66
Georgia	424	35	756	62
Hawaii ~	1,403	100	1,403	100
Idaho	317	26	407	33
Illinois	377	31	686	56
Indiana	288	24	378	31
Iowa	426	35	1,065	87
Kansas	403	33	493	40
Kentucky	526	43	909	75
Louisiana	174	14	264	22
Maine	1,829	150	1,919	157
Maryland	418	34	523	43
Massachusetts	1,621	133	1,621	133
Michigan	459	38	774	63
Minnesota ~	3,353	275	3,353	275
Mississippi	368	30	458	38
Missouri	1,219	77	1,309	77
Montana	478	39	836	69
Nebraska	535	44	669	55
Nevada	348	29	1,097	90
New Hampshire	600	49	750	62
New Jersey ~	2,438	200	2,438	25-37 #
New Mexico	389	32	704	58
New York ~	1,621	133	1,621	133
North Carolina	544	45	750	62
North Dakota	488	40	1,336	110
Ohio	1,219	100	1,219	100
Oklahoma	471	39	591	48
Oregon ~	1,219	100	1,219	100
Pennsylvania	403	33	677	56
Rhode Island ~	2,255	185	2,345	192
South Carolina	610	50	1,219	100
South Dakota	796	65	796	65
Tennessee	840	69	990	81
Texas	275	23	395	32
Utah	583	48	673	55
Vermont ~	2,255	185	2,345	192
Virginia	291	24	381	31
Washington	2,438	200	2,438	200
West Virginia	253	21	343	28
Wisconsin ~	2,255	185	2,255	185
Wyoming	590	48	790	65

Notes:
* Unless otherwise indicated, income eligibility is for Section 1931 Family Coverage.
~ Income eligibility levels are for state's Medicaid 1115 waiver.
FPL 100% of the federal poverty level (FPL) was $14,630 for a family of three in 2001.
\# In 2002, NJ stopped accepting new applications from working parents unless their incomes were below the state's income limit for welfare cash assistance. This effectively reduced the income limit for Medicaid eligibility to 25-37 percent of the FPL.

Source: Kaiser Commission on Medicaid and the Uninsured, *Enrolling Children and Families in Health Coverage: The Promise of Doing More* (Menlo Park: The Henry J. Kaiser Family Foundation, 2002), p. 40, Table 7. **Data current as of June 2001**

Information for Connecticut, Missouri, and New Jersey, Melanie Nathanson and Leighton Ku, *Proposed State Medicaid Cuts Would Jeopardize Health Insurance Coverage for 1.7 Million People: An Update* (Washington, D.C.: Center on Budget and Policy Priorities, 2003). **Data current as of March 2003**

Pregnant Women

Medicaid finances approximately one-third of all births in the U.S.[83] Medicaid coverage promotes access to prenatal care for beneficiaries, who are younger, poorer and in worse health than the general population, reducing their risk for problems such as low birthweight babies.[84] Medicaid must cover pregnant women at or below 133% of the FPL for pregnancy-related care and extends coverage through 60 days postpartum or through the last day of the month in which the 60 days expire.[85] To expand Medicaid coverage for pregnant women, states can expand income eligibility requirements and offer presumptive eligibility.

Eligibility Expansions

States have the option of expanding eligibility to pregnant women with incomes up to 185% of the FPL and beyond.[86] States may expand Medicaid coverage for pregnant women above the 185% threshold by disregarding a set amount of each applicant's income, such as the first $50.[87] Using this method, states have expanded coverage for pregnant women with incomes as high as 275% of the FPL.

Presumptive Eligibility

Another way states may expand coverage for pregnant women is to institute presumptive eligibility, which allows pregnant women who meet certain criteria to receive immediate, temporary Medicaid coverage while the application is processed.[88] This allows them to access prenatal health services as soon as they seek care.

TABLE III-2 MEDICAID COVERAGE EXPANSIONS FOR PREGNANT WOMEN

- 39 states and the District of Columbia have expanded Medicaid eligibility for pregnant women above the mandated 133% of the FPL.
  - 6 states cover pregnant women with incomes between 140% and 170% of the FPL.
  - 20 states and the District of Columbia cover pregnant women with incomes up to 185% of the FPL.
  - 13 states cover pregnant women at or above 200% of the FPL.
- 11 states cover pregnant women only up to the federally mandated 133% of the FPL.
- 30 states and the District of Columbia have presumptive eligibility for pregnant women.

Adults Without Dependent Children

Adults must be pregnant, parents of dependent children, over age 65, or have a disability to qualify for Medicaid.[89] Adults ages 19 to 64 who do not have children or with adult children are not typically eligible.[90] Only about 14% of women ages 18 to 64 who do not have dependent children are covered by Medicaid.[91] Of the 9.8 million low-income, uninsured childless adults, approximately 91% are ineligible for Medicaid coverage.[92] A handful of states have used 1115 waiver expansions to offer Medicaid benefits to childless adults. A smaller number of states finance coverage for adults without dependent children through separate state funds.

TABLE III-2 MEDICAID COVERAGE EXPANSIONS FOR ADULTS WITHOUT DEPENDENT CHILDREN

- 8 states have used 1115 waivers to expand Medicaid coverage to low-income childless adults. Eligibility levels range between 100% and 150% of the FPL.
- 3 states provide health coverage through separate state programs to childless adults with incomes ranging between 100% and 200% of the FPL.

TABLE III-2
Coverage Expansions for Pregnant Women and Childless Adults

State	Medicaid Coverage of Pregnant Women: Income Eligibility Limit^ (% FPL)	Medicaid Coverage of Pregnant Women: Presumptive Eligibility	Publicly Funded Coverage of Childless Adults: Income Eligibility Limit (% FPL)
United States Total		**30 + DC**	
Alabama	133		
Alaska	200		
Arizona	140		100*
Arkansas	200	●	
California	300#	●	
Colorado	133	●	
Connecticut	185		
Delaware	200	●	100*
District of Columbia	185	●	
Florida	185	●	
Georgia	235	●	
Hawaii	185		100*
Idaho	133	●	
Illinois	200	●	
Indiana	150		
Iowa	200	●	
Kansas	150	●	
Kentucky	185	●	
Louisiana	133	●	
Maine	200	●	
Maryland	250		
Massachusetts	200	●	133*
Michigan	185	●	
Minnesota	275		175**
Mississippi	185		
Missouri	185	●	
Montana	133	●	
Nebraska	185	●	
Nevada	133		
New Hampshire	185	●	
New Jersey	185	●	100**
New Mexico	185	●	
New York	200	●	100*
North Carolina	185	●	
North Dakota	133		
Ohio	150		
Oklahoma	185	●	
Oregon	170		100*
Pennsylvania	185	●	
Rhode Island	185		
South Carolina	185		
South Dakota	133		
Tennessee	185	●	100*
Texas	185	●	
Utah	133	●	
Vermont	200		150*
Virginia	133		
Washington	185		200**
West Virginia	150		
Wisconsin	185	●	
Wyoming	133	●	

Notes:
- ● State has the policy
- * 1115 Waiver
- ** Separate state program
- # California's Medicaid program extends eligibility to pregnant women through 200% of the FPL. The Access for Infants and Mothers (AIM) program extends eligiblity to pregnant women with incomes between 200% and 300% of the FPL.
- FPL 100% of the federal poverty level was $11,940 for a family of two in 2002.

Sources: **Information on Medicaid Coverage of Pregnant Women,** Emily Cornell, "Maternal and Child Health (MCH) Update: State Health Coverage for Low-Income Pregnant Women, Children, and Parents " National Governors' Association Report (June 9, 2003), Tables 2,8. **Data current as of October 2002**

Information on Publicly Funded Health Insurance Coverage of Childless Adults, "Expanding Coverage to Childless Adults," Families USA, unpublished data (January 2002). **Data current as of January 2002**

Seniors and People with Disabilities

Medicaid also plays an important role in the health care of low-income seniors and people with disabilities. While people age 65 and older and people with disabilities account for only 27% of Medicaid enrollment, they account for 71% of spending in the Medicaid program, with a large share of this attributed to long-term care.[93] Medicaid provides coverage to 5 million seniors and 8 million persons with disabilities.[94] Because women live longer and are more likely to require many of Medicaid's covered benefits, particularly professional long-term care services.[95] Women comprise nearly three-quarters of nursing home residents.[96] These services and Medicaid coverage of uncovered Medicare expenses are particularly important for women because the majority of low-income seniors are women.[97]

The extent of Medicaid assistance for the nation's poorest seniors and individuals with disabilities ranges in scope depending on their income and resources. (For a detailed discussion of Medicaid eligibility, please refer to the *Medicaid Resource Book*).[98] Those who qualify for Supplemental Security Income (SSI), a federal program that provides cash assistance to low-income individuals who are over 65 or blind or disabled, generally qualify for full Medicaid benefits. For example, a low-income Medicare beneficiary who also receives SSI is eligible for full Medicaid coverage. For a low-income Medicare beneficiary with an income that is greater than the SSI level, Medicaid assistance is limited to certain out-of-pocket Medicare costs such as premiums, deductibles, or copayments. Figure III-1 outlines the major federal guidelines for Medicaid eligibility for low-income Medicare beneficiaries. In addition, certain low-income people with disabilities who are not eligible for Medicare can also qualify for the full range of Medicaid benefits.[99]

FIGURE III-1 SELECT MEDICAID ELIGIBILITY PATHWAYS FOR MEDICARE BENEFICIARIES

	Family Income*	**Resource Test****	**Scope of Medicaid Coverage**
SSI Recipients	<$6,372 annually for individual; <$9,552 annually for family of two	100% SSI limit	Full Medicaid coverage
Qualified Medicare Beneficiaries (QMBs)	≤100% FPL	≤200% of SSI limit	All Medicare premiums and cost-sharing charges
Specified Low-Income Medicare Beneficiaries (SLMBs)	Between 100% and 120% FPL	≤200% of SSI limit	Medicare Part B monthly premium
Qualifying Individuals 1 (QI1s)	Between 120% and 135% FPL	≤200% of SSI limit	Medicare Part B monthly premium; benefit is subject to annual federal funding cap

* In 2001, the FPL was $11,610 for a family of two; 200% FPL was $23,220 for a family of two.

** In 2001, 100% of the annual Supplemental Security Income (SSI) resource level was $2,000 for individuals; $3,000 for couples.

Source: The Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book*, Washington, DC: The Henry J. Kaiser Family Foundation, pp. 33-40.

TABLE III-3
Coverage Expansions for Seniors and Adults With Disabilities

State	Coverage for SSP-Only Recipients (% FPL)	Expanded Eligibility for Medicare Benefs. (% FPL)	Medically Needy Income Limits (% FPL)	BBA or TWWIIA Expansion for Adults with Disabilities
United States Total				**26**
Alabama	74			
Alaska	137			●+
Arizona**	74			●◆
Arkansas	74		15	●◆
California	99	110	84	●+
Colorado	79			●◆
Connecticut	104		67~	●◆
Delaware	74			
District of Columbia	74	100	53	
Florida	74		25	●◆
Georgia	74		29	
Hawaii	75		51	
Idaho	81			
Illinois	74	100	40	
Indiana	74			●◆
Iowa	74		67	●+
Kansas	74		66	●◆
Kentucky	74		30	
Louisiana	74		13	
Maine	75	100	58	●+
Maryland	74		49	
Massachusetts	92	100	73	
Michigan	76	100	48	
Minnesota	85		67	●◆
Mississippi	74	142		●+
Missouri	74			●◆
Montana	74		71	
Nebraska	75	100	55	●+
Nevada	79			
New Hampshire	78		76	●◆
New Jersey	78	100	51	●◆
New Mexico	74			●+
New York	86		87	
North Carolina	74	100	34	
North Dakota	74	100	66	
Ohio	74			
Oklahoma	81	100		●◆
Oregon	74		58	●+
Pennsylvania	78	100	59	●◆
Rhode Island	83	100	87	
South Carolina	74	100		
South Dakota	76	100		
Tennessee	74		34	
Texas	74			●◆
Utah	74	100	53	●+
Vermont	82		95	●+
Virginia	74		30	
Washington	78		78	●◆
West Virginia	74		28	
Wisconsin	86		83	●+
Wyoming	75			

Notes:
- ● State has the policy
- ~ Higher income limits apply in some parts of the state; table shows lowest figure for the state.
- \+ Balanced Budget Act (BBA) of 1997 Option
- ◆ Ticket to Work and Work Incentives Improvement Act (TWWIIA) Option
- SSP State Supplemental Payment
- FPL 100% of the federal poverty level was $11,610 for a family of two in 2001.
- ** Arizona provides coverage up to 100% of the federal poverty level and allows a spend down to $279 monthly through a Section 1115 waiver

Sources: Families USA, *Could Your State Do More to Expand Medicaid to Seniors and Adults with Disabilities* (Washington, D.C.: Families USA, 2001). **Data current as of April 2001**

Information for Oklahoma (medically needy limit), Melanie Nathanson and Leighton Ku, *Proposed State Medicaid Cuts Would Jeopardize Health Insurance Coverage for 1.7 Million People: An Update* (Washington, D.C.: Center on Budget and Policy Priorities, 2003). **Data current as of March 2003**

Information on BBA/TWWIIA Expansions for Adults with Disabilities, Center for Workers with Disabilities, "Medicaid Buy-In Update" (American Public Health Association, Washington D.C. 2002), [Online] http://disabilities.aphsa.org/Resource%20Directory/MedicaidBuyIn.htm. **Data current as of April 2002**

Beyond these federal guidelines, states have several specific options for expanding Medicaid coverage to seniors and people with disabilities who are not eligible for SSI.

Coverage for Low-Income Seniors and People with Disabilities

Federal law generally mandates that Medicaid eligibility be extended to those who qualify for SSI (income thresholds for SSI are 74% of the FPL for individuals and 82% of the FPL for couples).[100] States must also provide partial Medicaid assistance, in the form of coverage for some Medicare expenses, to low-income seniors and people with disabilities with incomes up to and including 100% of the FPL. States have the option of providing full Medicaid coverage to Medicare beneficiaries with incomes up to 100% of the FPL.[101]

Coverage for SSP Beneficiaries

Most states augment federal SSI payments with State Supplemental Payments (SSP).[102] In some states, low-income seniors and people with disabilities who are ineligible for SSI may receive SSP if their income falls between the federal SSI limit and the state SSP limit.[103] These states may also expand Medicaid coverage to individuals who receive only SSP.[104]

"Medically Needy" Eligibility

Some individuals who are ineligible for Medicaid coverage based on SSI eligibility requirements may be eligible for Medicaid under a state's "medically needy" eligibility.[105] The "medically needy" category is intended to assist people with high medical expenses that consume a significant portion of their income, and cause them to "spend down" into poverty. States deduct medical expenses from a person's income, and if the remaining income is below the state's medically needy income limit, the person can qualify for Medicaid.

Medicaid Coverage for Working People with Disabilities

Both the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) give states the option of expanding Medicaid coverage to working adults with disabilities under the age of 65 with incomes above SSI qualifying levels.[106] Under the BBA, states can extend Medicaid coverage to people with disabilities under age 65 even if they have earnings above the Medicaid eligibility limit.[107] States have the flexibility to create their own income ceilings and can impose premiums or other cost-sharing charges.[108]

Under TWWIIA, states can set Medicaid income limits as high as they choose or eliminate income requirements completely.[109] States can charge premiums, and are required to charge the full premium to people with incomes exceeding $75,000.[110]

TABLE III-3 MEDICAID COVERAGE EXPANSIONS FOR SENIORS AND PEOPLE WITH DISABILITIES

- 23 states provide Medicaid coverage to seniors and people with disabilities who are eligible for State Supplemental Payments by extending eligibility beyond 74% of the FPL.
- 16 states and the District of Columbia extend full Medicaid coverage to seniors and people with disabilities with incomes up to or beyond 100% of the FPL.
- 33 states and the District of Columbia have a "medically needy" category for those with incomes ranging between 15% and 95% of the FPL.
- 11 states have implemented Medicaid expansions for adults with disabilities under the Balanced Budget Act and 15 states have expanded coverage under the Ticket to Work and Work Incentives Improvement Act.

MEDICAID MANAGED CARE

To control spending and improve access to services for beneficiaries, the majority of states have mandated that some or all of their Medicaid populations enroll in managed care plans. More than half of all people receiving services through the Medicaid program are now enrolled in managed care plans. In these programs, states contract with private managed care organizations (MCOs) to provide Medicaid-covered services to Medicaid beneficiaries. Beneficiaries are usually given a choice of several plans, but if they fail to choose one they are automatically enrolled in a plan. Beneficiaries in rural areas may not have a choice of plans.

There are three ways that states can mandate enrollment into Medicaid managed care programs. They can receive a Section 1115 or Section 1915(b) waiver from the federal requirement that gives enrollees freedom of choice to go to any provider that accepts Medicaid. In addition, Section 1932 of the Balanced Budget Act of 1997 allows states to mandate managed care enrollment without a waiver but with new statutory protections for enrollees.[111]

Low-income women and their children are the populations most likely to be covered by Medicaid managed care.[112] Eighty-two percent of non-elderly female Medicaid beneficiaries are enrolled in a managed care plan.[113] Access to family planning services is a special concern for low-income women of reproductive age enrolled in Medicaid managed care plans. Women who are required to enroll in a managed care plan may lose access to their previous reproductive health care provider if their doctor or clinic is not in their plan's network. Women may also enroll in or be automatically enrolled in a managed care plan that refuses to provide family planning services because it is owned by a religious entity that objects to these services (see Sections IV-3 through IV-5).[114] Medicaid's free access law helps protect against these barriers, but depending on a state's specific family planning structure (see Table III-5 for more information), many women are not covered under free access and may experience difficulties in accessing these reproductive health care services.

Managed Care Structure

The structure of states' Medicaid programs directly affects beneficiaries' access to services. Important structural differences include the way that states pay for care and if states mandate enrollment in managed care.

Capitation vs. Primary Care Case Management

States pay Medicaid managed care providers through either capitated MCOs or primary care case management (PCCM) systems. Under capitation, states pay MCOs a pre-negotiated, fixed fee for each enrollee's care. Under this system, beneficiaries are limited to providers in their MCO's network.[115] Under PCCM, each beneficiary is assigned to a primary care provider who is responsible for arranging and authorizing all the enrollee's covered services. These providers are paid on a fee-for-service basis for the direct services they provide and are paid a small monthly fee to manage the beneficiary's care.[116] Enrollees in this system are not limited to a network of providers, but must get approval from their primary care doctor to access additional services.

Mandatory Enrollment

Most states make enrollment in managed care mandatory for all or some Medicaid beneficiaries. Women of reproductive age are especially likely to be in the category of beneficiaries who are required to receive services through managed care plans.

TABLE III-4 STRUCTURE OF MEDICAID MANAGED CARE PROGRAMS AND COVERAGE OF FAMILY PLANNING SERVICES

- 30 states and the District of Columbia have capitated Medicaid managed care programs.
- 5 states utilize PCCM in their Medicaid programs.
- 11 states use both capitation and PCCM in different geographic areas.
- 35 states and the District of Columbia mandate enrollment in managed care for Medicaid beneficiaries.
- 8 states have voluntary Medicaid managed care enrollment; 3 states make enrollment mandatory in some areas but voluntary in others.
- 38 states and the District of Columbia include family planning services in their capitation rate; 3 states do not include family planning services in their capitation rate.
- 3 states exclude abortion services from their family planning capitation rate and 3 states exclude pharmacy services.

Family Planning Services

Although the federal government requires states to cover family planning services and supplies, federal Medicaid statutes do not define family planning.[117] According to the Centers for Medicare and Medicaid Services, a service must be "expected to achieve a family planning purpose" in order to receive an enhanced 90% federal family planning reimbursement rate.[118] States create their own definitions of family planning for their Medicaid managed care programs, which determines the scope of services covered. States generally cover gynecological exams, Pap smears, STD and HIV testing, FDA-approved forms of contraception and related counseling services, and contraceptive sterilization.[119] Preconception counseling and emergency contraception are considered family planning services in about half of the states, while infertility tests and treatment are rarely defined as family planning.[120] The U.S. Department of Health and Human Services has determined that abortion, while covered by Medicaid under limited circumstances, may not be defined as family planning.[121]

Two state policies are especially important in determining beneficiaries' access to family planning services under Medicaid managed care. The first is whether states include family planning services in the capitation rate. The second is how a state decides to inform enrollees of their right to receive family planning services from any provider.

TABLE III-4
Structure and Coverage of Managed Care Family Planning Services

State	Managed Care Structure	Mandatory or Voluntary Enrollment	Family Planning in Capitation Rate
	Managed Care Structure		
United States Total			**38 + DC**
Alabama	PCCM only	mandatory	N/A
Alaska	no managed care	no managed care	no managed care
Arizona	capitation only	mandatory	●
Arkansas	PCCM only	mandatory	N/A
California	capitation only	mandatory	●
Colorado	PCCM and capitation	mandatory	●
Connecticut	capitation only	mandatory	●
Delaware	capitation only	mandatory	●
District of Columbia	capitation only	mandatory	●
Florida	PCCM and capitation	mandatory	●
Georgia	PCCM and capitation^	voluntary	●
Hawaii	capitation only	mandatory	●
Idaho	PCCM only	voluntary	N/A
Illinois	capitation only	voluntary	●
Indiana	PCCM and capitation	mandatory	●
Iowa	PCCM and capitation^	mandatory	●
Kansas	capitation only	mandatory	
Kentucky	capitation only	mandatory	●
Louisiana	PCCM only	mandatory	N/A
Maine	PCCM and capitation^	voluntary	●
Maryland	capitation only	mandatory	●*
Massachusetts	PCCM and capitation	mandatory	●
Michigan	capitation only	voluntary	●
Minnesota	capitation only	mandatory	●
Mississippi	○	○	○
Missouri	capitation only	mandatory	●
Montana	capitation only	mandatory	●
Nebraska	capitation only	mandatory	●
Nevada	capitation only	varies	●
New Hampshire	capitation only	voluntary	●
New Jersey	capitation only	mandatory	●
New Mexico	○	○	○
New York	capitation only	varies	●***
North Carolina	PCCM and capitation^	varies	●
North Dakota	PCCM and capitation^	voluntary	●
Ohio	capitation only	mandatory	●
Oklahoma	capitation only	mandatory	●
Oregon	capitation only	mandatory	●
Pennsylvania	capitation only	mandatory	●
Rhode Island	capitation only	mandatory	●
South Carolina	capitation only	voluntary	
South Dakota	PCCM only	mandatory	N/A
Tennessee	capitation only	mandatory	●
Texas	PCCM and capitation^	mandatory	●
Utah	capitation only	mandatory	●***
Vermont	capitation only	mandatory	
Virginia	capitation only	mandatory	●*
Washington	capitation only	mandatory	●**
West Virginia	PCCM and capitation^	mandatory	●***
Wisconsin	capitation only	mandatory	●
Wyoming	○	○	○

Notes:
- ● State has policy
- ○ State did not respond/complete survey
- N/A State does not have capitation
- ^ Limited to certain counties
- * Abortion excluded from the capitation rate
- ** Abortion and sterilization excluded from the capitation rate
- *** Pharmacy services excluded from the capitation rate
- PCCM Primary Care Case Management

Source: The Henry J. Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services: Results of a National Survey* (Menlo Park: The Henry J. Kaiser Family Foundation, 2001), p. 32. Table III-1. **Data current as of January 2000**

Family Planning in Medicaid Managed Care Capitation Rates

When family planning services are included within a plan's capitation rate, it can be difficult for states to calculate the federal funding owed them under the special 90% reimbursement rate for family planning services because all services under capitation are paid for in a lump sum per beneficiary. There is a risk that that states may miss out on the enhanced reimbursement for family planning services, and as Medicaid plays a significant role in state budgets, maximizing reimbursement is vital for states and can affect the level of services that women receive.

The Free Access Law

In order to ensure access to family planning services under Medicaid managed care, most women enrolled in Medicaid managed care are free to go out of plan to receive family planning services from any participating Medicaid provider. This "free access" law (also referred to as "freedom of choice") is an important safeguard for women, allowing them to continue with existing family planning providers and access to family planning services if they are enrolled in a plan that doesn't provide such services, such as some faith-based plans.[122] A study of well-established managed care programs in five states found that one in ten Medicaid managed care enrollees used a provider not affiliated with her plan for contraceptive services.[123]

Whether or not free access/freedom of choice is available under Medicaid depends on how states choose to operate their managed care programs. The 19 states that operate their Medicaid managed care programs under an 1115 waiver are allowed to waive the free access provision.[124] Five of these 19 states do not provide free access to family planning services. An additional 21 states and the District of Columbia operate their Medicaid managed care programs under a 1915(b) waiver.[125] With the exception of Maine, which has a small voluntary program, all these states have free access for family planning services. States operating Medicaid managed care plans under Section 1932 are not permitted to restrict freedom of choice for family planning services and must inform enrollees of their right to obtain services from any provider.[126] Figure III-2 outlines structural rules for state implementation of the free access provision.

FIGURE III-2 MEDICAID MANAGED CARE AND FREE ACCESS

Managed Care Structure	**Free Access Enforcement**	**State Actions***
1115 waiver	May waive free access provision	Of the 19 states with these waivers, 5 do not provide free access to family planning services.
1915 waiver	Must enforce free access	21 states + DC
Section 1932	Must enforce free access	12 states
Voluntary managed care programs	May waive free access provision	Of the 8 states with voluntary managed care programs, 2 do not provide free access to family planning services.

*Totals more than 50 states and the District of Columbia, because states may use different waiver provisions for different populations of beneficiaries.

Source: The Henry J. Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services: Results of a National Survey,* 2001, p. 33.

TABLE III-5

State Approaches to Informing Beneficiaries About Family Planning Free Access

State	Responsibility for Informing Enrollees About Free Access			Medicaid Program Reviews Information or Provides Language	Method of Informing Enrollees
	Medicaid Program	Broker	Health Plan		
United States Total	**13**	**6**	**33 + DC**	**17**	
Alabama	N/A	N/A	N/A	N/A	N/A
Alaska	no managed care	no managed care	no managed care	no managed care	no managed care
Arizona	N/A	N/A	N/A	N/A	N/A
Arkansas	N/A	N/A	N/A	N/A	N/A
California			●		member handbook mailed within 7 days of enrollment
Colorado			●	●	member handbook
Connecticut			●		standard recipient notice
Delaware	●		●		notified at enrollment, plan newsletter & member handbook
District of Columbia			●		member handbook
Florida		●	●		broker counseling & member handbook
Georgia			●	●	plan marketing materials
Hawaii	N/A	N/A	N/A	N/A	N/A
Idaho	N/A	N/A	N/A	N/A	N/A
Illinois			●	●	member handbook
Indiana		●	●		member handbook & plan newsletter
Iowa			●	●	member handbook
Kansas			●		member booklet
Kentucky	N/A	N/A	N/A	N/A	N/A
Louisiana	N/A	N/A	N/A	N/A	N/A
Maine	N/A	N/A	N/A	N/A	N/A
Maryland	●		●	●	Medicaid brochure & plan informational materials
Massachusetts	●		●		new member packets
Michigan		●	●		enrollment agency & member handbook
Minnesota	●		●		Medicaid family planning brochure & plan informational materials
Mississippi	○	○	○	○	○
Missouri			●	●	member handbook
Montana		●	●	●	member handbook & enrollment broker interview
Nebraska		●	●		enrollment broker & member handbook
Nevada	●		●	●	member handbook
New Hampshire	●		●	●	plan welcome letter & enrollment information
New Jersey	●		●	●	Medicaid brochure, member handbook & list of family planning providers
New Mexico	○	○	○	○	○
New York	●		●	●	member handbook & state public education campaign
North Carolina	●		●	●	plan information & state Medicaid handbook
North Dakota			●	●	member handbook
Ohio			●		member handbook & periodic home visits
Oklahoma			●	●	member handbook
Oregon	○	○	○	○	○
Pennsylvania			●		member handbook
Rhode Island	N/A	N/A	N/A	N/A	N/A
South Carolina	●		●	●	plan information & state Medicaid handbook
South Dakota	N/A	N/A	N/A	N/A	N/A
Tennessee	N/A	N/A	N/A	N/A	N/A
Texas	●		●		member handbook, list of family planning providers & eligibility letter
Utah			●		plan orientation with new members
Vermont			●		○
Virginia	●				Medicaid enrollment brochure
Washington	●		●	●	member handbook
West Virginia		●	●		information mailed to enrollees
Wisconsin			●	●	member handbook
Wyoming	○	○	○	○	○

Notes: ● State has the policy
○ State did not respond/complete survey
N/A State is exempt from the free access requirement

Source: The Henry J. Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services: Results of a National Survey* (Menlo Park: The Henry J. Kaiser Family Foundation, 2001), p. 39, Table III-2. **Data current as of January 2000**

The way that states inform enrollees about free access has implications for women's access to reproductive health care, as many women may not be aware of their full range of choices. Literacy and language barriers are also important considerations for the Medicaid population. Some states require oral as well as written notification, which helps ensure that women are aware of their family planning access options.

TABLE III-5 STATE APPROACHES TO INFORMING MEDICAID BENEFICIARIES ABOUT FREE ACCESS

- 33 states and the District of Columbia place responsibility for informing Medicaid beneficiaries about free access on health plans; 17 of these states review the information provided to enrollees or provides the health plans with language to use.
- 6 states place responsibility for informing Medicaid beneficiaries about free access on independent Medicaid enrollment brokers.
- 13 states assume responsibility for informing Medicaid beneficiaries about free access.

MEDICAID COVERAGE OF ADDITIONAL SERVICES OF IMPORTANCE TO WOMEN

In addition to expanding the populations eligible for Medicaid, states have acted to expand Medicaid coverage for specific services that have particular importance for women's health. Women with limited resources face challenges ranging from how to obtain family planning services to how to support a spouse in a nursing home without becoming impoverished. State policies to extend Medicaid coverage of abortion and family planning services, breast and cervical cancer treatment, and to help low-income individuals with the cost of prescription medications are important extensions of the Medicaid program.

Abortion

The Medicaid program requires coverage of all medically necessary services.[127] However, the federal Hyde Amendment, first passed in 1977, bans state use of federal Medicaid dollars to pay for abortions unless the pregnancy is the result of rape or incest, or the abortion is "necessary to save the life of the woman."[128] States can cover other medically necessary abortions–usually defined by the state as those to protect the physical or mental health of the woman–for Medicaid recipients with their own funds. Of the 19 states that do fund most or all "medically necessary" abortions, four states fund them on a voluntary basis and 15 fund them under the order of state courts.[129]

TABLE III-6 STATE MEDICAID FUNDING OF ABORTION

- 23 states use their own funds to cover abortions under Medicaid beyond the federal requirement

  -19 states provide additional funding for most or all "medically necessary" abortions for Medicaid recipients; 5 of theses states have decided to fund medical as well as surgical abortions.

  -4 states provide additional limited funding for abortions for Medicaid recipients in cases of severe fetal deformity or other limited health conditions impacting the woman.
- 27 states and the District of Columbia follow federal Medicaid abortion funding restrictions, which limit publicly funded abortions to rape, incest and those necessary to save the life of the woman.

TABLE III-6
State Medicaid Funding of Abortion

State	State Funding Beyond Federal Provision	Funding Limitations
United States Total	**23**	
Alabama		
Alaska	●	
Arizona	●	
Arkansas		
California	●+	
Colorado		
Connecticut	●	
Delaware		
District of Columbia		
Florida		
Georgia		
Hawaii	●	
Idaho		
Illinois	●+	
Indiana	●	
Iowa	○	Limited to life endangerment, fetal deformity, mental deficiency or congenital illness.
Kansas		
Kentucky		
Louisiana		
Maine		
Maryland	●	
Massachusetts	●	
Michigan		
Minnesota	●+	
Mississippi	○	Funding is available in some cases of fetal abnormality.
Missouri		
Montana	●	
Nebraska		
Nevada		
New Hampshire		
New Jersey	●	
New Mexico	●	
New York	●+	
North Carolina		
North Dakota		
Ohio		
Oklahoma		
Oregon	●	
Pennsylvania		
Rhode Island		
South Carolina		
South Dakota		
Tennessee		
Texas	●*	
Utah		
Vermont	●	
Virginia	○	Limited to life or health endangerment, or gross and total fetal incapacitation, physical deformity or mental deficiency.
Washington	●+	
West Virginia	●	
Wisconsin	○	Limited to life endangerment, or to prevent grave, long-lasting physical health damage resulting from existing medical condition.
Wyoming		

Notes:
- ● State funds medically necessary abortions
- ○ State funds abortions on limited basis, but still beyond federal provision
- \+ Expressly includes medical abortion
- * Funding restriction ruled unconstitutional; restriction remains in effect pending appeal

Sources: National Conference of State Legislatures Health Policy Tracking Service unpublished data collected for this report (December 21, 2001); Alan Guttmacher Institute, State Policies in Brief (Washington, D.C.: Alan Guttmacher Institute, Feb. 2003).

Information on medical abortion funding, Danco Laboratories, *Reimbursement Facts* (Washington, D.C.: National Abortion Federation, undated) [Online]; http://www.earlyoptionpill.com/hcp_reimburse.php3. **Data current as of February 2003**

Section 1115 Family Planning Waivers

Many states have used Section 1115 waivers to extend coverage of family planning services to women who are not eligible for Medicaid. One way states have expanded access is by extending family planning services for a period of time beyond pregnancy and the 60-day postpartum period required by federal law.[130] The second way states have expanded coverage is by covering family planning services for a specific period of time for low-income women with incomes too high to qualify them for regular Medicaid coverage. One state, Delaware, expands coverage by providing two years of family planning services to women who become ineligible for Medicaid for any reason.

Family planning services provided under 1115 waivers vary by state and may also differ from the services provided under a state's regular Medicaid program. All states with family planning waivers cover prescription contraceptives and gynecological exams when conducted as a part of a family planning visit. Some states explicitly cover other services including testing and treatment for sexually transmitted diseases, including HIV, over-the-counter contraceptives, emergency contraception and contraceptive sterilization. Some programs also provide services for men.

TABLES III-7, III-8 SECTION 1115 FAMILY PLANNING WAIVERS AND SERVICES

- 16 states have approved section 1115 family planning waivers that allow them to extend family planning coverage to women who are not eligible for Medicaid.
- 4 states have pending 1115 family planning waivers to extend family planning services to women ineligible for Medicaid.
- In addition to prescription contraceptives, which all the states with Section 1115 family planning waivers cover, 8 states cover over-the-counter contraceptives and 3 states cover emergency contraception.
- 8 states cover STD testing and treatment and 3 states cover STD testing only; 8 states cover HIV testing.
- 13 states cover contraceptive sterilization; 3 of these states cover sterilization for men as well.
- 5 states cover additional health services such as transportation, home visits, interpreters and postpartum immunizations.

TABLE III-7
Section 1115 Family Planning Waivers

State	Approved Waiver	Eligibility Criteria	Length of Eligibility	Pending Waiver	Eligibility Criteria
United States Total	**16**			**4**	
Alabama	●	133% FPL	no time limit		
Alaska					
Arizona	●	postpartum loss of Medicaid if 140% FPL	2 years		
Arkansas	●	133% FPL	no time limit		
California	●	200% FPL (includes men)	1 year		
Colorado				●	150% FPL
Connecticut					
Delaware	●	loss of Medicaid for any reason	1 year, and 2nd year if 300% FPL		
District of Columbia					
Florida	●	postpartum loss of Medicaid*	2 years		
Georgia					
Hawaii					
Idaho					
Illinois					
Indiana					
Iowa					
Kansas					
Kentucky					
Louisiana					
Maine					
Maryland	●	postpartum loss of Medicaid if 185% FPL	5 years		
Massachusetts					
Michigan					
Minnesota					
Mississippi				●	185% FPL
Missouri	●	postpartum loss of Medicaid	2 years		
Montana					
Nebraska					
Nevada					
New Hampshire					
New Jersey					
New Mexico	●	185% FPL	2 years		
New York	●	200% FPL(includes men); postpartum loss of Medicaid if 185% FPL*	22 months		
North Carolina				●	185% FPL
North Dakota					
Ohio					
Oklahoma				●	185% FPL (includes men)
Oregon	●	185% FPL (includes men)	1 year		
Pennsylvania					
Rhode Island	●	postpartum loss of Medicaid if 250% FPL	2 years		
South Carolina	●	185% FPL	no time limit		
South Dakota					
Tennessee					
Texas					
Utah					
Vermont					
Virginia	●				
Washington	●	200% FPL (includes men)	no time limit		
West Virginia					
Wisconsin	●	185% FPL			
Wyoming		information not available			

Notes: ● State has approved or pending family planning waiver
* Extends Medicaid after any pregnancy-related service, not just delivery
FPL 100% of the federal poverty level (FPL) was $11,940 for a family of two in 2002.

Sources: Alan Guttmacher Institute, *State Policies in Brief* (Washington, D.C.: Alan Guttmacher Institute, Feb. 2003); The Henry J. Kaiser Family Foundation, *Section 1115 Medicaid Family Planning Waivers* (Menlo Park: The Henry J. Kaiser Family Foundation, October 2001). **Data current as of February 2003**

Information on Alabama and Washington eligibility, National Women's Law Center, unpublished data collected for this report, May 2002.

Information on Arkansas, California, New Mexico, Oregon, South Carolina eligibility, The Henry J. Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services: Results of a National Survey* (Menlo Park: The Henry J. Kaiser Family Foundation, 2001), p. 56, Table IV-2.

Information on Washington and Oregon services for men, National Conference of State Legislatures unpublished data collected for this report (Nov. 2001).

TABLE III-8
Services Explicitly Included in Section 1115 Family Planning Waivers

State	Over-the-Counter Contraceptives	STD Testing/ Treatment	HIV Testing	Emergency Contraception	Sterilization	Other Health Care Services
United States Total	**8**	**11**	**8**	**3**	**13**	**5**
Alabama			●		●	
Alaska						
Arizona	●	○*	●	●	●	
Arkansas		○			●	full medical exam, 3x/yr. follow-up visits
California	●	●	●	●	●**	physical exam
Colorado						
Connecticut						
Delaware	●	●	●		●	
District of Columbia						
Florida		●	●		●	transportation
Georgia						
Hawaii						
Idaho						
Illinois						
Indiana						
Iowa						
Kansas						
Kentucky						
Louisiana						
Maine						
Maryland		●	●		●	
Massachusetts						
Michigan						
Minnesota						
Mississippi						
Missouri		●			●	
Montana						
Nebraska						
Nevada						
New Hampshire						
New Jersey						
New Mexico		●			●	
New York	●	●	●			
North Carolina						
North Dakota						
Ohio						
Oklahoma						
Oregon	●				●**	home visits, interpreters
Pennsylvania						
Rhode Island	●	○*	●		●	up to three follow-up family planning visits, postpartum rubella immunization
South Carolina	●				●	
South Dakota						
Tennessee						
Texas						
Utah						
Vermont						
Virginia						
Washington	●	●		●	●**	
West Virginia						
Wisconsin						
Wyoming						

Notes:
- ● State has policy
- ○ Covers STD testing only
- * Program makes referral for low/no cost treatment
- ** Program covers men also

Sources: National Conference of State Legislatures unpublished data collected for this report (Nov. 2001). **Data current as of November 2001**

The Henry J. Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services: Results of a National Survey* (Menlo Park: The Henry J. Kaiser Family Foundation, 2001), pp. 56, 59-61. **Data current as of January 2000**

Information on Washington STD treatment, Washington State Department of Social and Health Services, *Take Charge Program* (Olympia: Washington State Department of Social and Health Services, May 2002), [Online] http://wws2.wa.gov/dshs/maa/familyplan/TCclientservices.html. **Data current as of May 2002**

Breast and Cervical Cancer Treatment Coverage Expansions

Nationwide, every year, an estimated 13,000 women are diagnosed with cervical cancer and more than 200,000 women are diagnosed with breast cancer.[131] More than 43,700 women die from these two diseases annually.[132] Access to screening and treatment for these cancers is crucial because both can be detected in the earliest stages and respond well to early medical intervention.[133] However, women who are uninsured or underinsured may skip routine screening for these diseases.

To address this problem, Congress passed the Breast and Cervical Cancer Mortality Prevention Act of 1990, which established the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).[134] Under the program, the CDC was authorized to promote and pay for breast and cervical cancer screening and follow-up diagnostic services for uninsured or low-income women. The CDC formed a network of providers to implement the screening program. The law, however, did not authorize payment for the treatment of women diagnosed with breast or cervical cancer under this program. To fill this gap, Congress passed the Breast and Cervical Cancer Prevention and Treatment Act of 2000. Under this law, states have the option to provide full Medicaid benefits for the duration of treatment to uninsured women under age 65 who are diagnosed with cervical or breast cancer through the NBCCEDP. States that exercise this option receive enhanced Medicaid matching funds from the federal government.[135] All states have opted to participate in this program, but have adopted different policies that affect who is covered (Figure III-3).

States must receive approval from the federal government to participate in the program and must specify which of three eligibility options they will cover.

FIGURE III-3 BREAST AND CERVICAL CANCER TREATMENT PROGRAM ELIGIBILITY OPTIONS

Eligibility Option	Scope of coverage	State participation
1	Any woman screened by a provider in the NBCCEDP network	Mandatory
2	Any woman screened by a provider who receives some CDC funds to support screening services	Optional
3	Any woman screened by a provider the state decides to consider as part of screening network	Optional

Source: Centers for Medicare and Medicaid Services, *Breast and Cervical Cancer Prevention and Treatment Activity Map* [Online] cms.hhs.gov/bccpt/bccptmap.asp, accessed February 26, 2003.

Each state that chooses to participate must cover Option 1, also known as "the basic option." Under Option 1, any woman screened by a provider in the CDC screening network is eligible for treatment. Under Option 2, any woman screened by a non-CDC network provider who receives some CDC funds to support screening services is eligible for treatment. Under Option 3, any woman screened by a provider the state decides to consider part of the CDC screening network is eligible for treatment.[136]

States may also offer presumptive eligibility to applicants who appear to be eligible for the program, which allows women to enroll on a temporary basis and receive services while their Medicaid applications are processed, allowing them timely care.[137]

TABLE III-9 MEDICAID BREAST AND CERVICAL CANCER TREATMENT COVERAGE EXPANSIONS

- 50 states and the District of Columbia have chosen to participate in the federal program to expand Medicaid coverage for the treatment of breast and cervical cancers in low-income women.
  - 49 states and the District of Columbia have approved plans.
  - 1 state has enacted legislation that indicates a plan will be submitted.
- 25 states have selected Option 1 only;
  - 12 have selected Options 1 and 2;
  - 4 have selected Options 1 and 3,
  - 7 have selected all three options.
- 22 states have presumptive eligibility for the program.

TABLE III-9
Breast and Cervical Cancer Treatment Coverage Expansions

State	Participating in Federal Program	Screening Option	Presumptive Eligibility
United States Total	**50 + DC**		**22**
Alabama	●	1	
Alaska	●	1, 2	
Arizona	●	1	
Arkansas	●	1, 2, 3	
California	●	1, 3	●
Colorado	●	1	●
Connecticut	●	1	●
Delaware	●	1, 2	●
District of Columbia	●	*	*
Florida	●	1	
Georgia	●	1, 2, 3	●
Hawaii	●	1	
Idaho	●	1	●
Illinois	●	1, 2	
Indiana	●	1	
Iowa	●	1, 3	●
Kansas	●	1	
Kentucky	●	1, 2	
Louisiana	●	1, 2	
Maine	●	1	
Maryland	●	1, 2	
Massachusetts	●#	*	*
Michigan	●	1, 2, 3	
Minnesota	●	1	●
Mississippi	●	1, 2, 3	●
Missouri	●	1	●
Montana	●	1	
Nebraska	●	1, 3	●
Nevada	●	1, 2	●
New Hampshire	●	1, 2	●
New Jersey	●	1, 2	●
New Mexico	●	1	●
New York	●	1, 2	●
North Carolina	●	1	
North Dakota	●	1, 2	
Ohio	●	1	
Oklahoma	○		
Oregon	●	1	●
Pennsylvania	●	1	
Rhode Island	●	1, 2, 3	●
South Carolina	●	1	
South Dakota	●	1	
Tennessee	●	1, 2, 3	●
Texas	●	1	●
Utah	●	1, 2, 3	
Vermont	●	1	
Virginia	●	1	
Washington	●	1, 2	
West Virginia	●	1, 3	●
Wisconsin	●	1	●
Wyoming	●	1	

Notes:
- ● State has policy
- ○ State does not have an approved plan, but has enacted legislation that indicates plan will be submitted.
- * Additional information on the state's screening option/presumptive eligibility was not available.
- # Funding for Massachusetts' program was cut before the program started running.

Sources: Centers for Medicare and Medicaid Services, "Breast and Cervical Cancer Prevention and Treatment Activity Map," [Online] http://cms.hhs.gov/bccpt/bccptmap.asp. **Data current as of December 2002**

Information on states that do not have a plan but have enacted legislation, National Conference of State Legislatures, "State Legislation Relating to the Breast and Cervical Cancer Prevention and Treatment Act of 2000," [Online] http://www.ncsl.org/programs/health/cancerch.htm. **Data current as of July 2002**

Spousal Impoverishment Protection Policies

Medicaid is the largest payer of long-term care services,[138] and women constitute the majority of long-term care recipients.[139] Of the 1.5 million seniors living in nursing homes, approximately 75% are women.[140] Medicaid pays for 46% of the $87.8 billion spent on nursing home care, which accounts for three-fourths of all long-term care spending.[141]

Eligibility for Medicaid coverage of nursing home care is based on need. In the past, seniors were required to spend down their resources to qualify for assistance. This often left their spouses (called "community spouses") the choice of living in poverty or divorcing their spouses to preserve their assets such as a house. To protect the community spouses, who are disproportionately women, "spousal impoverishment" protections were enacted.[142]

Federal law requires states to protect the assets and income of the community spouse by permitting them to keep a "resource allowance" and an "income allowance."[143] States set these levels within federal guidelines. For the income allowance, states must allow the community spouse to retain a portion of the institutionalized spouse's income according to the state's Minimum Monthly Maintenance Needs Allowance, which must be between $1,451.25 and $2,175.[144] For the resource allowance, states must allow the community spouse to retain annually the greater of a minimum of $17,400 and a maximum of $87,000 in assets; or half the couple's joint assets up to $87,000.[145]

TABLE III-10 INCOME AND RESOURCE ALLOWANCES FOR SPOUSES OF NURSING HOME RESIDENTS

- 15 states and the District of Columbia permit community spouses to retain the maximum $2,175 per month of the Minimum Monthly Maintenance Needs Allowance.
- 33 states permit the community spouse to retain the minimum Monthly Maintenance Needs Allowance.
- 2 states permit the community spouse to retain an amount between the minimum and the maximum.
- 18 states and the District of Columbia permit the community spouse to retain the maximum resource allowance.
- 24 states permit the community spouse to retain the minimum resource allowance.
- 8 states permit the community spouse to retain an amount between the minimum and maximum resource allowance.

TABLE III-10

Spousal Impoverishment Protections - Income and Resource Allowances for Spouses of Nursing Home Residents

State	Minimum Monthly Maintenance Needs Allowance ($)	Annual Community Spouse Resource Allowance ($)
United States Total	**17+DC***	26 + DC*
Alabama	1,451	87,000
Alaska	2,175	87,000
Arizona	1,451	17,400
Arkansas	1,451	17,400
California	2,175	87,000
Colorado	1,451	87,000
Connecticut	1,451	17,400
Delaware	1,451	25,000
District of Columbia	2,175	87,000
Florida	1,451	87,000
Georgia	2,175	87,000
Hawaii	2,175	87,000
Idaho	1,451	17,400
Illinois	2,175	87,000
Indiana	1,451	17,400
Iowa	2,175	87,000
Kansas	1,451	17,400
Kentucky	2,175	87,000
Louisiana	2,175	87,000
Maine	1,451	87,000
Maryland	1,451	17,400
Massachusetts	1,451	87,000
Michigan	1,451	17,400
Minnesota	1,451	24,607
Mississippi	2,175	87,000
Missouri	1,451	17,400
Montana	1,451	17,400
Nebraska	1,451	17,400
Nevada	1,451	17,400
New Hampshire	1,451	17,400
New Jersey	1,451	17,400
New Mexico	1,451	31,290
New York	2,175	74,820
North Carolina	1,451	17,400
North Dakota	2,175	87,000
Ohio	1,451	17,400
Oklahoma	2,175	25,000
Oregon	1,451	17,400
Pennsylvania	1,451	17,400
Rhode Island	1,451	17,400
South Carolina	1,662	66,480
South Dakota	1,451	20,000
Tennessee	1,451	17,400
Texas	2,175	17,400
Utah	2,175	17,400
Vermont	1,451	87,000
Virginia	1,451	17,400
Washington	1,451	87,000
West Virginia	1,451	17,400
Wisconsin	1,875	50,000
Wyoming	2,175	87,000

Note: * Number of states whose allowance exceeds the federal minimum of $1,451 for minimum montly maintenance needs allowance and $17,400 for resource allowance.

Source: Eric Carlson, "Long-Term Care Advocacy Appendices, Section 7.401, State-Specific Chart of Resource and Income Allowance, and Average Monthly Private Pay Rates," (Los Angeles: Lexis Publishing, 2001), 7-133 to 7-135. **Data current as of December 2001**

Prescription Drug Coverage

Coverage for prescription drugs under Medicaid is an optional benefit, but all 50 states and the District of Columbia provide this coverage in their Medicaid programs. States have flexibility to determine the scope of coverage of their Medicaid prescription drug programs and may place limits on prescription coverage, including copayments and limits on the number of refills or prescriptions allowed per month or per year.

Prescription drug coverage is one of the most widely utilized benefits in the Medicaid program, accounting for $16.6 billion of Medicaid expenditures in 2000.[146] However, many women on Medicaid still have problems affording prescription drugs. One-quarter of women who receive Medicaid report that they did not fill a prescription due to the cost.[147] The Medicaid program does not have a uniform prescription drug benefit, and as with other benefits, prescription drug coverage and policies vary by state. States may require some beneficiaries to make minimal copayments, but are prohibited from charging copayments to pregnant women, children or people in institutions or for emergency or family planning services, and may not deny services to people who cannot afford the copayment.[148] (Information about separate non-Medicaid state pharmaceutical assistance programs is contained in Table V-5).

TABLE III-11 STATE MEDICAID PRESCRIPTION DRUG COVERAGE

- 50 states and the District of Columbia provide prescription drug coverage under Medicaid.
- 15 states place limits on the number of prescriptions Medicaid recipients may receive per month or per year.
- 31 states and the District of Columbia require a copayment for prescriptions that ranges from $0.50 to $3.00 per prescription.

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Medicaid is an important source of health care access for low-income women. For women in their reproductive years, Medicaid's role as a financier of family planning and prenatal care services is critical. Trends in Medicaid access for women have generally been positive. Most states have expanded eligibility for the parents of children covered by Medicaid and for pregnant women. Access to family planning and screening and treatment for breast and cervical cancer have also been enhanced through the Medicaid program, although access to abortion is still extremely limited under the program. For seniors and women with disabilities, Medicaid provides critical assistance for prescription drugs, long-term care, and with Medicare cost-sharing.

The current economic downturn has put additional pressures on states to reduce spending. Many states are looking to Medicaid to cut costs. This could have serious repercussions for access to coverage and care for low-income women.

TABLE III-11
Prescription Drug Coverage

State	Prescription Drug Coverage	Copayment Required ($)	Limits on Number of Prescriptions
United States Total	**50 + DC**	**31 + DC**	**15**
Alabama	●	.50-3.00	
Alaska	●	2.00	
Arizona	●		
Arkansas	●	.50-3.00	3 per month
California	●	1.00	6 per month without prior authorization
Colorado	●	.50-2.00	
Connecticut	●		
Delaware	●		
District of Columbia	●	1.00	
Florida	●		4 per month brand; unlimited generic
Georgia	●	0.50	5 per month without prior authorization
Hawaii	●		
Idaho	●		
Illinois	●		varies by drug
Indiana	●	3.00	
Iowa	●	1.00	
Kansas	●	2.00	
Kentucky	●		
Louisiana	●	.50-3.00	Viagra only (6 per month)
Maine	●	.50-3.00	
Maryland	●	1.00	
Massachusetts	●	0.50	
Michigan	●	1.00	
Minnesota	●		
Mississippi	●	1.00	10 per month
Missouri	●	.50-2.00	
Montana	●	1.00-2.00	
Nebraska	●	1.00	
Nevada	●		6 per month
New Hampshire	●	.50-1.00	
New Jersey	●		
New Mexico	●		
New York	●	.50-2.00	43 per year
North Carolina	●	1.00	6 per month
North Dakota	●		
Ohio	●		
Oklahoma	●	1.00-2.00	3 per month; unlimited for recipients under age 21
Oregon	●		
Pennsylvania	●	1.00	
Rhode Island	●		
South Carolina	●	2.00	4 per month
South Dakota	●	2.00	
Tennessee	●		7 per month
Texas	●		3 per month; unlimited for recipients under age 21, nursing home residents
Utah	●	1.00 (5.00/month limit)	
Vermont	●	1.00-2.00	
Virginia	●	1.00	
Washington	●		
West Virginia	●	.50-2.00	10 per month without prior authorization
Wisconsin	●	.50-1.00	
Wyoming	●	2.00	

Notes: ● State has the policy

Source: Renee Schwalberg and others, *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey and Selected Case Study Highlights* (Washington, D.C.: The Henry J. Kaiser Family Foundation, 2001), Tables 1, 5, 7. **Data current as of mid-2000**

Information for Arizona, conversation with Branch McNeil, Deputy Director, Arizona Health Care Cost Containment System, July 3, 2001. **Data current as of mid-2000**

Information for Colorado, Ohio (copay only), Oklahoma, Texas, and Wisconsin, National Pharmaceutical Council, *Pharmaceutical Benefits Under State Medical Assistance Programs* (Reston, VA: NPC, 2000), 4-48, 4-51. **Data current as of mid-2000**

Information for Ohio (limits only), conversation with Robert Reid, Pharmacy Program Coordinator, Ohio Department of Job and Family Services, July 3, 2001. **Data current as of mid-2000**

Information for Tennessee, "Copay Implementation Rules," March 7, 2001, [Online] http://www.state.tn.us/tenncare/copayimp.html; Tennessee Department of Finance and Administration, Bureau of TennCare, "General Rules: 1200-13-1-.03: Amount, Duration, and Scope of Assistance," March 2002 (Revised), [Online] http://www.state.tn.us/sos/rules/1200/1200-13/1200-13-01.pdf. **Data current as of mid-2000**