

Women and Medicaid:

NWLC Toolkit for Advocates



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Medicaid Access:

*A Critical Source of Health Care
for Low-Income Women*

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What is Medicaid?

- The nation's major public health insurance program for low-income Americans
- Established in 1965
- Focused on welfare population (single parents with dependent children) and aged, blind and disabled
- An entitlement program

What Does Medicaid Do?

- Medicaid provides health and long-term care coverage for close to *55 million low-income people*:
 - Comprehensive low-cost health coverage for 41 million
 - Acute and long term care coverage for 14 million elderly and disabled, including over 6 million Medicare beneficiaries

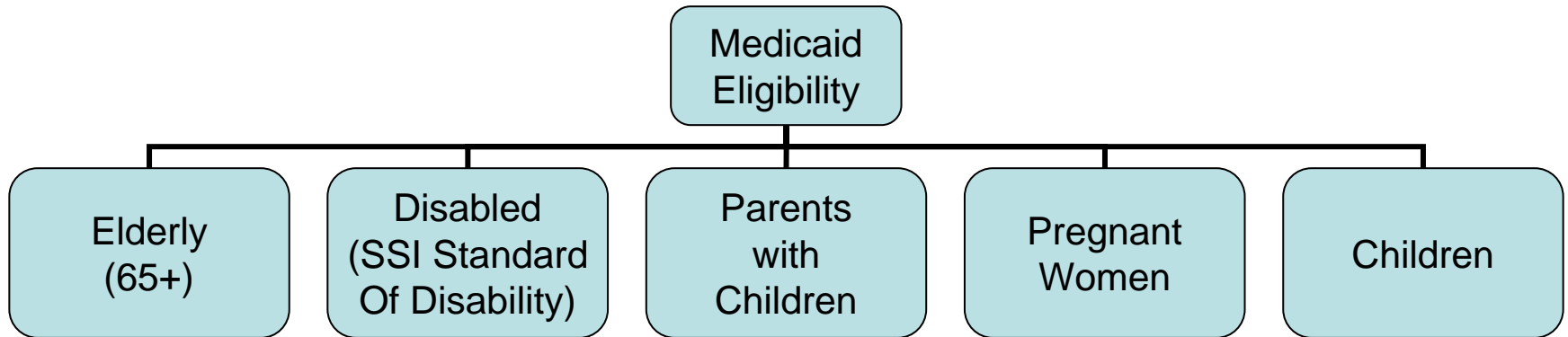
How Does Medicaid Work?

- Run jointly by the federal and state governments
- Each state administers its own program under federal guidelines
- Federal government contributes a share of the program's cost
- Federal share is based on formula that accounts for varying degrees of poverty in the state

Recent Changes to the Program

- Deficit Reduction Act (DRA) of 2005
 - Enacted changes to Medicaid law
 - Will focus on three
 - Benefit packages
 - Cost-sharing requirements
 - Citizenship documentation
 - Did not change who qualifies, how the program is financed or the entitlement nature of the program

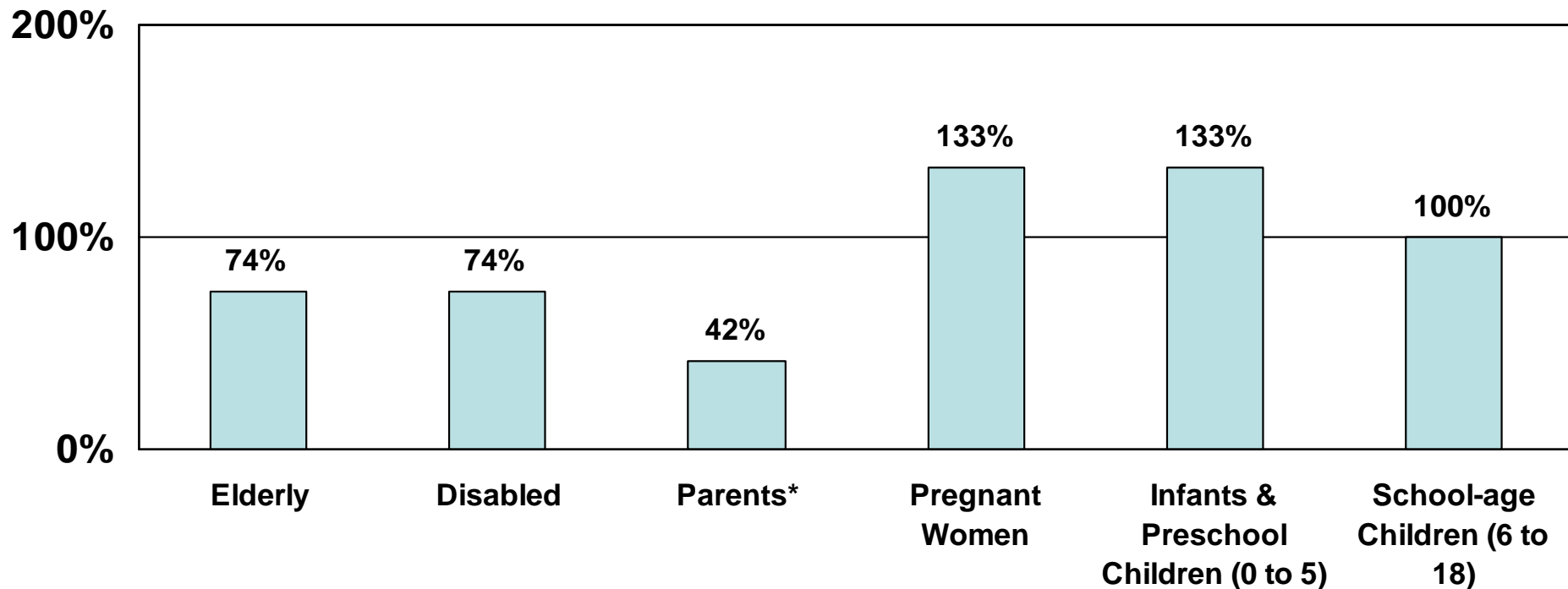
Who Qualifies?



Individuals in each group must meet financial and other non-financial criteria.

Medicaid Mandatory Income Eligibility, 2006

Percent of Federal Poverty Level



* AFDC average for 1996, which is the minimum standard now used for Section 1931 eligibility
The Federal Poverty Level is \$16,600 for a family of three for 2006.

What Is Covered?

Before the DRA:

- Mandatory and Optional Benefits

After the DRA:

- Allows states to use “benchmark” benefits for certain groups
- Maintains current benefits for mandatory adults and individuals with disabilities
- Maintains EPSDT for children as a wrap around

What Cost-Sharing is Allowed?

Before the DRA:

- Exempted certain populations and services from cost-sharing
- Set “nominal” rate for all others

After the DRA:

- Allows states to impose higher or new cost-sharing and premiums
- Maintains exemptions for mandatory children and pregnant women, except for non-preferred prescription drugs

Where Do Women Fit In?

Facts on Women and Medicaid

- Over 70 % of adult beneficiaries are women
- Women are *twice* as likely as men to qualify
- Nearly one in ten women in the US receives health care coverage through Medicaid
- One third of all poor women are covered by Medicaid

Medicaid and Women of Reproductive Age

- 10 % of women of reproductive age (15-44) receive their health care through Medicaid
- Over 40% of all US births are financed by Medicaid
- Medicaid is the single largest source of public funding for family planning services

Women as Parents

- Medicaid parents are more likely to be women – the “moms”
- Low-income parents are *unlikely* to have employer-sponsored insurance
- Medicaid is the largest insurer of single mothers, covering 40% of this population

Elderly Women

- Dual eligibles – term used to describes the 6 million Medicare beneficiaries that are poor enough to qualify for Medicaid
- Women live longer, have higher rates of disability and continue to have lower incomes and assets in senior years
- Per enrollee cost high – \$1 in \$4 Medicaid dollars goes to services for elderly

Women and Health Insurance

- Rising health care costs has had a disproportionate effect on women because of lower incomes and their greater need for health care services across their lifespan.
- In the past three years, the insurance premium paid for by employees has increased 50% for family coverage.

Medicaid as a Safety Net

- Private health insurance is usually not an option for the Medicaid population
- Low income workers lack access to employer-sponsored insurance
 - Not offered
 - Even if offered, many can not afford it
- In the absence of Medicaid, the vast majority of its beneficiaries would join the ranks of the 46 million uninsured Americans.

MEDICAID 101: The Federal-State Health Care Partnership

What is Medicaid?

*Medicaid is the largest source of health care funding for the poor in the U.S., serving one in six Americans or close to 53 million people.*¹ Medicaid guarantees eligible individuals coverage for primary, acute and long-term care services. The program is run jointly by the federal and state governments, with each state administering its own Medicaid program under federal guidelines, and the federal government contributing more than half of the program's costs.²

Medicaid is an entitlement program, which means that *anyone who meets the stringent eligibility requirements can enroll in the program* and there is no limit on the number of people allowed into the program.

There are five main categories of eligible people: (1) Children, (2) Parents, (3) Pregnant Women, (4) People with Disabilities, and (5) the Elderly. Beyond these categories, eligibility is determined based on financial considerations, with a federally defined income threshold for each group and a limit on assets.³ States may seek approval through an application to the federal government called a "waiver" if they want to alter their program in any way that would not meet federal Medicaid requirements.

What is Covered by Medicaid?

Since its early years, the Medicaid program has guaranteed its beneficiaries access to key health services, including physician services, laboratory and x-ray services, inpatient and outpatient hospital care, nursing home care and family planning supplies and services.⁴ Many states have opted to go beyond federal requirements and provide coverage of "optional" services, such as coverage for prescription drugs.⁵ Unfortunately, the recently passed budget law called the Deficit Reduction Act (DRA) allows states to replace even the traditional Medicaid package with reduced benefit packages for certain groups.⁶

¹ IssuesPA, *Medicaid 101 – An Overview of a Federal-State Partnership*. at <http://www.issuespa.net/articles/10933/> (accessed June, 2005).

² National Health Policy Forum, *The Basics: Medicaid Financing*. The George Washington University, September 14, 2004. at http://www.nhpf.org/pdfs_basics/Basics_MedicaidFinancing.pdf

³ Almanac of Policy Issues, *Medicaid: A Program Overview*. U.S. Department of Health and Human Services, Health Care Financing Administration – *A Profile of Medicaid: 2000 Chartbook*, Section 1, September 2000.

⁴ For a comprehensive list of all mandatory services, refer to Centers for Medicare & Medicaid Services, *Medicaid – A Brief Summary*, <http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp> (accessed August 29, 2005).

⁵ "In addition to the mandated benefits packages, states may provide additional "optional" services. All fifty states do." Anna Sommers, Ph.D., Arunabh Gosh, B.A., The Urban Institute and David Rousseau, M.P.H., The Kaiser Commission on Medicaid and the Uninsured. *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefits Categories*. June 2005.

⁶ For more information about what services could be lost under the DRA, please see *Medicaid Cuts: Benefits May Be Reduced for Women Under the DRA* at http://www.nwlc.org/pdf/FSMedicaidandtheDRA_04.21.06.pdf

Who Pays for Medicaid?

Medicaid was created in 1965 to serve as the primary health care program for the poor. A partnership was created between the state and federal governments to allow both to share the financial burden of the program and to provide health care to the most vulnerable Americans. ***Because the federal government commits to paying at least half the cost of Medicaid, the program has a fiscal incentive for states to extend health care coverage to their low-income residents.***

Costs for the program are divided between the federal and state governments based on a matching rate, called the federal medical assistance percentage or “**FMAP**.” The FMAP is calculated based on a formula that uses each state’s per capita income to account for varying degrees of poverty among the states.⁷ Wealthier states, which have higher per capita incomes, receive less federal support than poorer states. Currently, FMAPs range from a minimum of 50% in states like California and New York to a maximum of 76% in Mississippi.⁸

States generally may charge a co-payment or insurance premium, known as **cost-sharing**, to beneficiaries for the care they receive, including prescription medication. However, traditionally, some groups and services were exempt from cost-sharing in order to ensure their use of needed health care.⁹ Unfortunately, the DRA now allows states to impose new or higher cost sharing on most Medicaid beneficiaries. States may not require cost-sharing for services for mandatory children and pregnant women. Very significantly, the DRA grants providers the right to *deny* services or drugs if a beneficiary cannot pay the cost-sharing amount at the point of service. This individual then not only faces a loss of care for a particular health need, but also faces the loss of his/her health insurance all together.

Medicaid Covers More People (and Costs More) When the Economy Is Weak

Medicaid is *counter-cyclical*, meaning that it expands to cover more people when weak economic times lead more individuals to become eligible for the program.¹⁰ Therefore, as the need grows and more enter the program, federal financial support also grows. The fact that Medicaid is an entitlement program has ensured the program’s ability to cover more uninsured, low-income people when the economy suffers a downturn.¹¹ ***If the federal government were to provide funding for Medicaid only through limited amounts of money rather than providing matching funds for all state expenditures as it does through the FMAP, states would come up short during hard times, and they would not be able to meet the growing demands during an economic slump.***¹²

Ways to Expand Medicaid Coverage

⁷ Glossary of Home Health Care and Health Care Terms, “FMAP is a percentage of Federal matching dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher Federal matching rate to States with lower per capital income.” at

http://www.healthcarewebdesign.com/glossary_healthcare_homecare_terms/glossaryF.php (accessed July 2005)

⁸ *Federal Financial Participation in State Assistance Expenditures*, FY 2006 Federal Register: November 24, 2004 (Volume 69, Number 226).

⁹ For more information on the effects of cost-sharing on low-income populations, please see *Increased Cost-Sharing in Medicaid Hurts Women and their Families* at <http://www.nwlc.org/pdf/6-2005MedicaidCost-Sharing.pdf>.

¹⁰ Leighton Ku, *CDC Data Show Medicaid and SCHIP Played A Critical Counter-Cyclical Role In Strengthening Health Insurance Coverage During Economic Downturn*. The Center on Budget and Policy Priorities, Revised October 8, 2003.

¹¹ *Id.*

¹² *Id.*

States can expand Medicaid coverage in various ways. One way is to raise the income at which people are eligible.¹³ States must cover eligible populations (known as mandatory populations) up to a certain percentage of the federal poverty level. But states can go beyond this level and cover individuals at higher incomes. Currently, all states go above some federal minimums to cover portions of these so-called “optional” populations. Another way to expand coverage is to streamline the enrollment process by eliminating the asset test. Even when their income meets eligibility criteria, many individuals do not enroll because they encounter barriers to enrollment. One such barrier is the asset test, which counts parents’ ownership of certain assets when determining the family’s eligibility for Medicaid. Removing this test eases the application process, streamlines and reduces administrative costs and increases the pool of eligible individuals. In 2004, 21 states had eliminated the asset test for parents.

States may also allow working individuals with disabilities the option of *buying into Medicaid*. Under this option, working individuals with disabilities, who because of their earnings cannot qualify for Medicaid, can pay a monthly premium in an amount equal to the difference between their income and the maximum income eligibility level set by their state.¹⁴ In total, 31 states allow certain populations to utilize the buy-in option to receive benefits.¹⁵

States also may seek permission through *a waiver* to use federal Medicaid funds to cover more categories of people than those required by federal law.¹⁶ Waivers were designed to let states try “research and demonstration” to institute projects that “further the objectives of the [Medicaid] program.”¹⁷ Unfortunately, in an attempt to contain costs, many states are now using these waivers to limit Medicaid enrollment and benefits while increasing the cost to recipients rather than using the waivers to expand coverage.

Cutting Medicaid Severs the Federal-State Partnership and Hurts Beneficiaries

Recent efforts to cut federal funding to Medicaid could have dire consequences for the program’s beneficiaries, the majority of whom are women. An inadequate federal commitment exposes these women and their families to inevitable cuts in coverage or a reduction in benefits at the state level. As health care costs continue to rise and access to employer-sponsored insurance decreases, the federal government must continue to carry its fair share of the Medicaid financing burden and stay true to its historical commitment to this health insurance safety net.

¹³ 42 U.S.C. §§ 1396-1396v; 42 C.F.R. Ch. IV; 45 C.F.R. Subtitle A.

¹⁴ *Medicaid Eligibility*, Centers for Medicare & Medicaid Services. at <http://www.cms.hhs.gov/eligibility/criteria.asp> (accessed June 2005)

¹⁵ Allen Jensen, *Variables Impacting Participation in a State’s Medicaid Buy-In Program: Medicaid Eligibility “Starting Points” and Restrictions in Medicaid Buy-In Program*. Draft, September 4, 2003. at http://www.uiowa.edu/~lhpdc/work/III_Framework/2003_TablesA_B_StartPoints.doc

¹⁶ *Medicaid Section 1115 Waivers: Current Issues*, Kaiser Commission on Medicaid and the Uninsured. Key Facts, January 2005.

¹⁷ *Id.*

The Efficiency of Medicaid

Many misconceptions exist with respect to the cost and efficiency of the Medicaid program. Those who favor a massive overhaul of the system often paint a picture that Medicaid costs are “spiraling out of control” and must be stopped. Upon closer inspection, while there are ways to improve the program, as a whole, Medicaid is currently more efficient than even the private market.¹

Medicaid Saw Increased Costs in Early 2000

The Medicaid program underwent a severe period of fiscal stress from 2001 to 2004. During this period, state revenues were decreasing and Medicaid spending and enrollment growth was increasing. *The increase in Medicaid enrollment in those years was due to weak economic times and a decrease in the availability of employer-sponsored insurance.* Medicaid enrollment for families (non-disabled adults and children) grew by 11.6 percent between 2000 and 2002 and by another 7.1 percent between 2002 and 2003.² These enrollment increases, which occurred during a recession and slow economic recovery, are evidence that Medicaid worked as intended. The economic downturn that began in early 2001, combined with a double-digit increase in inflation, made many more people eligible for Medicaid.³ Structured as an entitlement program, Medicaid is designed to work as a safety net that expands during weak economic times.⁴ When the economy is in recession and states are short on money, unemployment figures rise.⁵ As a result, a greater number of people become eligible for Medicaid benefits.⁶ Studies have shown that in 2002, if Medicaid had not responded to the weak economy by providing coverage to the unemployed, the number of uninsured would have been several millions higher.⁷

Medicaid Costs Today

As states' fiscal budgets have rebounded, the Medicaid program costs have also slowed. In fact, total Medicaid spending increased in state fiscal year 2006 by only 2.8% on average, which is slowest rate of growth in Medicaid since 1996.⁸ The fiscal year 2006 is also the first year since 1998 that state revenues grew at a faster rate than total Medicaid spending.⁹ Given the improved

¹ Medical Study News, *Study explains reason behind recent Medicaid spending growth.* at http://www.news-medical.net/print_article.asp?id=7537

² Kaiser Commission on Medicaid and the Uninsured. *Medicaid Enrollment and Spending Trends.* June 2005

³ *The Uninsured: A Primer. Key Facts About Americans Without Health Insurance.* The Kaiser Commission on Medicaid and the Uninsured, November 2004.

⁴ Leighton Ku, *CDC Data Show Medicaid and SCHIP Played Critical Counter-Cyclical Role In Strengthening Health Insurance Coverage During The Economic Downturn.* Center on Budget and Policy Priorities, October 8, 2002.

⁵ David Shactman and Michael Doonan, *Reimagining Medicaid: Policy Brief.* Council on Health Care Economics and Policy, November 2002.

⁶ Id.

⁷ Leighton Ku, *CDC Data Show Medicaid and SCHIP Played a Critical Counter-Cyclical Role in Strengthening Health Insurance Coverage During the Economic Downturn.* Center on Budget and Policy Priorities, October 8, 2003.

⁸ Vernon Smith et al., *Low Medicaid Spending Growth Amid Rebounding State Revenues.* The Kaiser Commission on Medicaid and the Uninsured, October 2006.

⁹ Ibid.

economic picture that states face today, it is not surprising that enrollment in Medicaid also slowed to 1.6%, as an improved economy resulted in fewer people becoming eligible for the program. Another major contributing factor to slowed spending growth is the passage of the Medicare Modernization Act which transitioned over 6 million low-income seniors and individuals with disabilities from Medicaid drug coverage to the newly created Medicare Part D plans in January 2006.

Medicaid is a Cost Efficient Program

Critics of Medicaid often focus on so-called “fraud, waste and abuse” in the program. However, one study showed that fraud and abuse in Medicaid only accounted for .007% of the Medicaid budget.¹⁰ It is also overlooked that Medicaid is more efficient than private insurance with much lower administrative costs. Overall, Medicaid costs have risen at *nearly half the rate* of private insurance costs.¹¹

The Medicaid Program is Good for States’ Economies

For every dollar invested in Medicaid, three dollars of business activity is generated in the form of local jobs and wages, in revenues for hospitals and other providers, as well as in support of community health facilities.¹² The fact that states are required to pay half of all Medicaid costs also creates a strong incentive to run the program efficiently and keep costs down. The following chart demonstrates how cuts would harm state economies.¹³

State	Economic Impact
Arkansas ¹⁴	\$100 million in state Medicaid funding generated \$533 million in economic activity, created over 10,000 jobs for Arkansas and produced nearly \$306 million in income. For every \$1 dollar spent by the state government on Medicaid, \$4 dollars gets added to the gross state product.
Maryland ¹⁵	For every \$1 million in Medicaid cuts, the state would lose \$2.27 in lost business activity and \$800,000 in lost wages. Every \$1 million cut would also result in 22 lost jobs.
North Carolina ¹⁶	Due to Medicaid budget cuts, the state has lost 9,700 jobs and \$706,257,420 in revenue.

¹⁰ John Reichard, “Baucus Mounts Spirited Defense of Current Medicaid Spending Levels,” *CQ Health Affairs*, January 19, 2005 (citing recent CMS report).

¹¹ John Holahan and Arunabh, “Understanding the Recent Growth in Medicaid Spending, 2000-2003,” *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

¹² Alliance for Health Reform, *Sourcebook for Journalists*, 2004, pg 63.

¹³ The individual state information was compiled by the National Mental Health Association, in a report entitled *Measuring the Economic Impact of State Medicaid Programs*. Links for each individual state will be provided in the corresponding footnote information.

¹⁴ Economic and Fiscal Impact of Additional \$100 Million in State Funding for Medicaid Programs, University of Arkansas, Arkansas Business & Communities, Dr. Miller, Wayne; Dr. Pickett, John, March 24, 2003; http://www.arcommunities.org/econ_dev/Economic/economicimpact/mcicaid.asp

¹⁵ Medicaid: Good Medicine for MD’s Economy, Advocates for Children and Youth Fiscal Facts; http://www.acy.org/web_data/good_medicine.pdf.

¹⁶ The Economic impact of Proposed Reduction in Medicaid Spending in North Carolina; Institute for Public Health, School of Public Health, University of North Carolina, Kilpatrick, Kerry; Olnick, Joshua; Lugar, Michael; Koo, Jun; Office of economic Development; Kenan Institute of Private enterprise; April 11, 2002; <http://www.healthlaw.org/pubs/2002/NC.econimpact.doc>

West Virginia ¹⁷	A 10% cut in federal Medicaid match funds will result in a \$188.1 million in business volume, 3,268 jobs and \$66.7 in employee compensation
Wisconsin ¹⁸	A 10% cut in Medicaid and Badger care funding will have an accompanying loss of \$240 million in wages, salaries and other types of income. After initial impact, additional losses would total 9,100 jobs and \$394 million in income.

Proposals Seeking to Limit Federal Funding to States Will Hurt Beneficiaries

Many reform proposals involve capping federal funds to the Medicaid program. If federal contributions to the Medicaid program are capped, the state will be left to shoulder the burden of increasing costs. Given the trend in health care costs, when these costs increase, the state will have to make up any differences without federal assistance, which will be near impossible under current state budget conditions. This will force the state to scale back their program, which often mean eligibility and/or benefit reductions.

Expanding Not Cutting, Medicaid Resources Are the Answer

Reducing spending on Medicaid is fiscally unsound and would increase the numbers of uninsured, which costs taxpayers more in the long-run. Instead of searching for ways to cut the program, reform measures should focus on ways to reach even more people and relieve the program's burden of long term health services and rising health care costs.

¹⁷ Economic Impact of Medicaid Federal Match – Match on the West Virginia Economy; Dr. Christiadi; Dr. Witt, Tom, Bureau of Business and Economic Research College of Business and Economics; West Virginia University; January, 2003l c.2002, West Virginia Research Corporation.

¹⁸ Economic Impact of Reducing Medicaid and Badger Care Expenditures; Wisconsin Council on Children & Families, Voices for Wisconsin's children, Prof. Deller Steven PhD, Madison, UW, February 11, 2003; <http://www.wccf.org/pdf/economicimpact.pdf>

Health Care for the Poor: Who Is Eligible for Medicaid

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.¹ Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

Income Eligible Groups under Medicaid:

- (1) **Children** – A child up to age 6 becomes eligible by residing in a family of 3 with an income at or below \$1,839/month or 133% of the FPL. A child between 6 and 19 qualifies if their family income is \$1,383/month or 100% of FPL. Most states opt to cover children with family incomes up to \$2,559/month or 185%.
- (2) **Parents** – A parent becomes eligible for Medicaid if he or she has a dependent child and falls at or below the income standard used by the state for its welfare program in July of 1996. These income levels vary greatly by state and are considerably lower than those of other eligible categories. The median required income eligibility level for parents is only 31% of FPL, or \$426 per month. A state does have the option of covering parents above these minimum requirements and all but 9 have opted to do so. The median optional income eligibility level for working parents is \$904 per month or 65% of FPL.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$1,839/month (or 133% of FPL) for her family of 3. Coverage extends throughout the pregnancy and for 60 days postpartum. States can opt to cover women whose income is higher, and most do.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$605/month, the income standard used to determine eligibility for Supplemental Security Income (SSI).² Many states go beyond this level and cover people with disabilities at or below \$1383, or 100% of FPL.
- (5) **Elderly Populations** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their incomes are low enough. Seniors can get coverage for the full Medicaid benefits package plus assistance with Medicare premiums and cost-sharing or just the latter. Income levels vary depending on how the individual qualifies, but at minimum, these standards mirror those of the SSI program. Many states have chosen to cover people at or below \$1383 or 100% of FPL.

¹ There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets.

² There is one notable exception to this minimum income level. Some states exercise what is known as a 209(b) option which allows states to use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972.

Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.³ Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women under age 65 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC) and do not have other health care coverage may qualify for the basic Medicaid benefits package.
- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage. The population served by waivers varies by state. Some states cover all women and men who meet the income eligibility level. Other states only cover women post-partum for a specified number of years. Other states cover only women over 19 years old.

³ To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

The Federal Poverty Level: What Is It and Why Does It Matter?

The Federal Poverty Level (FPL) is meant to define the monetary level under which an individual or family is considered to be “living in poverty.” However, the FPL is too low to represent a realistic household budget and is thus not an accurate indication of poverty. Nonetheless, the FPL is the primary determinant of who does and does not qualify for many government aid programs.

How is the Federal Poverty Level determined?

The FPL was originally determined in 1963 by taking the cost of the Department of Agriculture’s “economy food plan” and multiplying it by three. According to information available at the time, one-third of a family’s post-tax income was spent on food with the remainder spent on other goods and services.¹

Adjusted annually to reflect inflation, the FPL for 2006 is \$20,000 for a family of four with income including general earnings, unemployment compensation, worker’s compensation, income from Social Security payments, alimony or child support, financial assistance from outside sources, and many other things. If a family’s annual income falls below this number, they are considered to have income below the poverty level.²

FPL: Not an Accurate Measure of Poverty

Use of the FPL is often criticized for its failure to reflect a typical family in the modern world, as it has not changed since its inception more than four decades ago. Of critical importance is the outdated assumption that one-third of a family’s income is spent on food. Recent estimates have determined food to account for closer to one-fifth of a family’s budget.³

However, even if food did account for one-third of a family’s budget, the economy food plan is described by the Department of Agriculture as being “designed for temporary or emergency use when funds are low.”⁴ Thus, paying such a small amount for food consumption is not considered sustainable for a significant amount of time.

In addition, the FPL calculation does not take into account such factors as child care because, when it was created, it could be assumed that families had one wage-earner and one person who stayed at home.⁵ It also fails to address new changes in the standard of living as well as the fact that health care coverage and costs vary for different population groups.

Perhaps most crucially, the FPL does nothing to address the fact that the cost of living changes dramatically depending on where a family is located. High housing costs in large cities are

¹ Fisher, Gordon M. “The Development and History of the U.S. Poverty Thresholds – A Brief Overview”

² United States Department of Health and Human Services, “The 2006 HHS Poverty Guidelines”

³ International Union, United Automobile, Aerospace and Agricultural Implement Workers. uaw.org

⁴ Fisher, Gordon M. “The Development and History of the U.S. Poverty Thresholds – A Brief Overview”

⁵ Willis, Jessie. “How We Measure Poverty: A History and Brief Overview” Oregon Center for Public Policy. www.ocpp.org.

especially burdensome for poor families. If adjustments were made to the poverty level based on variants in housing rental costs across geographic regions, the highest poverty rates would not be in Mississippi, New Mexico, and Arkansas as previously understood, but rather in Washington, D.C., followed by New York City and the entire state of California. This indicates that poverty programs such as Medicaid are inadvertently providing inequitable services to people facing significantly different costs of living.⁶

Example of the FPL at Work

To put the concept of the FPL into perspective, consider how a family would qualify for Medicaid in two different states. In Alabama, a working parent qualifies for Medicaid if her income is at below 26% of the FPL, which in 2006 translates to about \$366 a month. If that same parent were to move the neighboring state of Georgia, she could make twice that and still qualify (a parent is eligible for Medicaid if her income is 55% of FPL or roughly \$756 a month).

⁶ Reed, Deborah. "Poverty in California: Moving Beyond the Federal Measure," *California Counts: Population Trends and Profiles*. Vol. 7, #4. May 2006.

Poor Parents on Medicaid Targeted for Cuts

Medicaid is the largest source of health insurance for poor and low-income Americans and provides a safety net for those with the greatest need. Parents are among Medicaid's neediest population, and yet current Medicaid reform proposals seek to remove many of them from Medicaid's protections.

Coverage for Low Income Parents is in Jeopardy

In the wake of the Deficit Reduction Act of 2006, some of the neediest beneficiaries, like parents, may face benefit reductions and increased cost-sharing. As a result, many parents, already on painfully tight budgets, may be unable to secure necessary health coverage.

Medicaid is an Important Source of Health Insurance for Parents

Medicaid is often the only possible source of health insurance coverage for low-income parents, who are unlikely to have employer-based or other health insurance.¹ More than one-third of low-income parents, whose incomes were below 200% of the federal poverty level (FPL), lacked health insurance in 2005.² Without Medicaid, far more of these parents would be uninsured.

Coverage for Parents Matters

Medicaid coverage has ensured that parents have access to many important health services, including acute care, hospital care, preventive screenings, pregnancy-related care, mental health services and family planning services.³ Research shows that Medicaid coverage is essential not only to the health of parents but also to the health of their children, who are more likely to be enrolled in health insurance and get services if their parents are also enrolled.⁴

Only the Lowest-Income Parents Qualify for Medicaid

To qualify for Medicaid, an individual must have a low enough income to meet the federally set "mandatory" income eligibility standard, or the higher "optional" level set by the state. While the numbers vary by state, the mandatory income level for parents is much lower than for other categories of eligible individuals, as can be seen in the chart at right.

Eligibility category	Mandatory Level of Coverage
Parents (family of 3)	12%-65% ⁵
Aged and Disabled	74%
Pregnant Women	133%
Children	133%

Women are more likely to qualify as beneficiary parents under Medicaid than are men. This is because women tend to be poorer; they are more likely to meet the stringent income eligibility level for parents; and they are more likely to head single parent households.

States must provide Medicaid coverage to parents who meet the income, resource and family composition rules⁶ that were in place on July 16, 1996 in their individual state welfare programs. All of these eligibility levels are well below the current FPL and range from \$164 to \$872 a month for a family of three. **The median required income eligibility level for parents is only 31% of FPL, or \$426 per month, and leaves two thirds of poor parents without health care assistance.**

Even Expanded Coverage for Parents is Very Low in Most States

Prior to 1996, anyone receiving cash assistance through welfare automatically became eligible for Medicaid. However, welfare reform in 1996 required people to apply separately for welfare and Medicaid.

States can cover more parents by expanding Medicaid coverage beyond the required income eligibility standard.

Although all states currently provide coverage to parents above the lowest federal minimum standard, only **15 states** have raised their eligibility levels above the FPL. **The median income level for "optional" parents who are working is only 65% of FPL, or \$904 per month for a family of three.** (See Chart 1, over.)

CHART 1: A Comparison of the Mandatory and Optional Income Eligibility Levels for Parents

STATE	Mandatory minimum level ⁷ (1996 AFDC level in monthly \$ amount for a family of 3)	% of FPL (2006) ⁸	Optional Medicaid level for Working Parents ⁹ (monthly \$ amount for a family of 3)	% of FPL (2006)
US Median	\$426	31%	\$904	65%
Alabama	\$164	12%	\$366*	26%
Alaska	\$1028	60%	\$1401	81%
Arizona	\$347	25%	\$2767	200%
Arkansas	\$204	15%	\$255*	18%
California	\$730	53%	\$1473	107%
Colorado	\$421	30%	\$920*	67%
Connecticut	\$872	63%	\$2166	157%
Delaware	\$338	24%	\$1473	107%
District of Columbia	\$420	30%	\$2867	207%
Florida	\$303	22%	\$806	58%
Georgia	\$424	31%	\$756	55%
Hawaii	\$712	45%	\$1591	100%
Idaho	\$317	23%	\$595*	43%
Illinois	\$377	27%	\$2649	192%
Indiana	\$288	21%	\$378*	27%
Iowa	\$426	31%	\$1065	77%
Kansas	\$429	31%	\$493*	36%
Kentucky	\$526	38%	\$909	66%
Louisiana	\$190	14%	\$280*	20%
Maine	\$553	40%	\$2857	207%
Maryland	\$373	27%	\$524	38%
Massachusetts	\$565	41%	\$1840	133%
Michigan	\$459 ¹⁰	33%	\$848	61%
Minnesota	\$532	38%	\$3806	275%
Mississippi	\$368	27%	\$458*	33%
Missouri	\$292	21%	\$556	40%
Montana	\$541	39%	\$854	62%
Nebraska	\$364	26%	\$804	58%
Nevada	\$348	25%	\$1185	86%
New Hampshire	\$550	40%	\$781	56%
New Jersey	\$443	32%	\$1591*	115%
New Mexico	\$389	28%	\$903	65%
New York	\$577 ¹¹	42%	\$2075	150%
North Carolina	\$544	39%	\$750	54%
North Dakota	\$431	31%	\$904	65%
Ohio	\$341	25%	\$1245	90%
Oklahoma	\$307	22%	\$591	43%
Oregon	\$460	33%	\$1383	100%
Pennsylvania	\$421	30%	\$842	61%
Rhode Island	\$554	40%	\$2649	192%
South Carolina	\$200	14%	\$1340	97%
South Dakota	\$507	37%	\$796	58%
Tennessee	\$583	42%	\$1113	80%
Texas	\$188	14%	\$402	29%
Utah ¹²	\$568	41%	\$673	49%
Vermont	\$650	47%	\$2649	192%
Virginia	\$240	17%	\$427	31%
Washington	\$546	39%	\$1092	79%
West Virginia	\$253	18%	\$499	36%
Wisconsin	\$517	37%	\$2649	192%
Wyoming	\$590	43%	\$790	57%

Note: Some states have, since July 2006, changed their income eligibility levels for parents.

Mandatory Level for Parents:

48 states are at or below 50% FPL (\$692 per month for a family of 3)

3 states are above 50% FPL

No state is above 63% FPL (\$872 per month for family of 3)

Optional Levels for Parents:

*9 states have not used their option to expand coverage

13 states at or below 50% FPL (\$692 per month for a family of 3)

36 states at or below 100% (\$1383 per month for a family of 3)

15 states above 100% FPL

10 states at or above 150% (\$2075 per month for a family of 3)

References

- ¹ Sixty-four percent of employers of the working poor do not offer health insurance and, even when they do, workers often can't afford to enroll. Stan Dorn, "Medicaid Coverage for Poor Adults: A Potential Building Block for Bipartisan Health Reform," Economic and Social Research Institute, November, 2004.
- ² Matthew Broaddus and Leighton Ku, "Coverage for Parents Helps Children, Too," Center on Budget and Policy Priorities, Oct. 20, 2006.
- ³ Unfortunately, this year's Deficit Reduction Act threatens all mandatory services by allowing states to create reduced benefit packages for certain beneficiaries. To learn more about the potential effects of this new law, please see *Medicaid Cuts: Benefits May Be Reduced for Women Under the DRA* at http://www.nwlc.org/pdf/FSMedicaidandtheDRA_04.21.06.pdf
- ⁴ Donna Cohen Ross and Laura Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge* (Washington: Kaiser Commission on Medicaid and the Uninsured, July 2004).
- ⁵ See Chart 1 for a list of current mandatory eligibility levels in all 50 states and the District of Columbia.
- ⁶ Family composition rules refer to the requirement that the family be either a single parent family or a two parent family in which the principal earner is unemployed (i.e. does not work more than 100 hours a month).
- ⁷ House Ways and Means Committee, *The 1996 Green Book Overview of Entitlement Programs*, Washington, DC, 1996 available at <http://aspe.hhs.gov/96gb/contents.htm#toc>
- ⁸ The Federal Poverty Level in 2006 is \$16,600 for a family of three in the 48 continuous states, \$20,750 in Alaska and \$19,090 in Hawaii.
- ⁹ The income level for parent eligibility was obtained from Table 3, "Income Threshold for Parents Applying for Medicaid, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, December 2006, unpublished data. Calculations for percent of the federal poverty level were determined using 2006 federal poverty guidelines.
- ¹⁰ Michigan has different payment schedules by region. The standard chosen is the lowest.
- ¹¹ New York has different payment schedules by region. The standard chosen is the lowest.
- ¹² Utah's expanded Medicaid program – known as the Primary Care Network – provides a limited benefits package with enrollment fees and co-payments and is subject to enrollment cap.

Health Savings Accounts Are Not the Answer for Women and their Families

Health Savings Accounts (HSAs) have been heavily promoted as a central health care component of President Bush's health care reform agenda. Unfortunately, this short-sighted remedy fails to solve the dual problems of rising health insurance costs and the staggering number of uninsured women and families.

What is an HSA?

An HSA is a specific account funded by the employer and/or employee to be used by the employee to purchase health services. These accounts are designed to be combined with a health insurance plan that has a high deductible. To be eligible for an HSA, an individual must be covered by a health plan that has an annual deductible of at least \$1,000 for single coverage and \$2,000 for family coverage. Employee contributions are not taxed, nor are distributions from the account for qualified health expenses.

Employers can offer HSAs as the only form of coverage for their employees or they can be provided as an alternative for an employee to participating in the comprehensive ESI plan. Employers may favor these accounts because premiums for high deductible plans are less than premiums for comprehensive coverage. These accounts, often referred to as "consumer directed arrangements" can be used in some form for all types of coverage, including the individual market and Medicare and Medicaid.

How HSAs Work

An HSA in the private health insurance market belongs to the individual and therefore remain with the individual to be used to cover his/her medical expenses, regardless of whether he or she changes employers or the new employer offers HSAs. However, people with less income to contribute to the HSA may not have enough funds in their accounts to cover their health care needs in a given year. Also, depending on the design of the high deductible plan, there may be holes in coverage that will require individuals to pay substantial out-of-pocket costs until they meet the high deductible and the plan begins reimbursing for services.

HSAs are part of President Bush's goal of promoting an "ownership society." Like the President's attempt to privatize the social security system, HSAs are intended to give Americans more control over their choices and investments. In the process of independently managing and spending their own health care funds, individuals are supposed to become more educated about the prices of health care services, which should ostensibly lead them to spend their funds more responsibly. Health plans rarely provide any cost or quality information about providers so it is difficult to see how consumers will be able to make such informed decisions. Additionally, HSAs are designed to be used as a tax-saving method to accumulate funds for health care expenses in retirement. However, recent evidence suggests that these accounts are more often being used as tax shelters by higher-income individuals.¹

¹ Edwin Park and Robert Greenstein, "GAO Study Confirms Health Savings Accounts Primarily Benefit High-Income Individuals." Center on Budget and Policy Priorities, September 20, 2006.

Why HSAs Too Often Fail Uninsured Women and Families

While the goals behind HSAs may have merit, in practice, HSAs fail to provide the improved and expanded health care for uninsured women and families that they promise

- ***Too few low-income people benefit from HSAs.*** The majority of uninsured people are poor and lack the money necessary to subsidize the \$1,000 or more that is necessary to invest in an HSA. Even those low-income individuals who can afford to meet their deductibles may not have enough funds in their accounts to cover their remaining health care needs in a given year. While one of the stated goals of HSAs is to reduce overuse of health care services, the increased cost-sharing that comes with such an account can lead to the underuse of needed services, particularly for low-income people and those with chronic illnesses.² This means that rather than seeking preventive care or undergoing medical treatment, people will delay or forgo health care services to avoid paying out-of-pocket expenses that they simply cannot afford. A recent examination of early experiences with HSAs has also shown that such accounts tend to primarily benefit individual with higher incomes and in good overall health.³
- ***Women in particular will be disproportionately disadvantaged by HSAs.*** Women typically require more health care services than men and are more likely than men to have trouble paying for their care (whether or not they are insured) because they are of lower income. Thus, women with less disposable income and/or higher health care needs are less well-served by an HSA than a comprehensive employer-sponsored plan primarily because they will face higher out-of-pocket payments from the high-deductible plan and are less likely to be able to cover the difference through their tax savings. Because women typically need and use more health care than men, high out-of-pocket costs can discourage needed health care use for women. And, women may be less likely to use preventive services – key to early detection and treatment of disease – if faced with high cost sharing.
- ***HSAs may harm traditional employer-sponsored health care plans and increase the number of uninsured.*** Because HSAs shift costs from employers to employees, many employers may begin to favor HSAs over traditional employer-sponsored health care plans, which include low deductibles, modest co-payments, and comprehensive benefits. Even within companies, comprehensive health plans can be compromised if most of the healthy employees choose to use HSAs. When older and sicker individuals are left in traditional health insurance plans, premiums in these plans are likely increase to accommodate the higher costs incurred. This could cause premiums to rise out of the reach of many employees and leave even more individuals uninsured. In fact, one study estimates that HSAs will raise the number of uninsured by 600,000.⁴

² A recent study found that those in high deductible health plans were more likely to have high out-of-pocket payments and to avoid or delay care. Paul Fronstein and Sara Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, The Commonwealth Fund, December 2005.

³ Government Accountability Office, “Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans,” GAO-06-798, August 8, 2006.

⁴ Jonathon Gruber, The Cost and Coverage of Impact of the President’s Health Insurance Budget Proposal, Center for Budget and Policy Priorities, <http://www.cbpp.org/2-15-06health.htm>

Women and Medicaid

Medicaid, the national health insurance program for poor and low-income people, plays a critical role in providing health coverage for low-income women. Women are the majority of the adult Medicaid population, comprising nearly 71 percent of beneficiaries ages 19 and older. Women are twice as likely as men to qualify for Medicaid (eight and four percent respectively) because they tend to be poorer and are more likely to meet the stringent eligibility criteria. Women are also more likely to be in low-paying jobs that do not offer employer-sponsored insurance. Therefore Medicaid is often the only possible source of health insurance coverage for this population. Despite efforts to expand Medicaid access to more low-income women, millions still remain uninsured and that number is increasing.

Nearly one in ten women in the U.S. receives health care coverage through Medicaid.

- One third of all poor women are covered by Medicaid.
- Medicaid is the largest source of health insurance for single mothers and covers almost 40% of this population.

Medicaid ensures that women have access to a panoply of important health care services.

- Mandatory services include acute care, physician and hospital care, preventive screenings, pregnancy-related care, mental health services and family planning services.
- Medicaid provides diagnosis and treatment of chronic illnesses including breast and cervical cancer and HIV/AIDS.

Medicaid is important for low-income women of *all* ages.

- For elderly women, the program covers high-cost nursing-home and long-term care services.
- More than 6 million low-income reproductive-age women rely on Medicaid for their basic health care.

Reproductive health services in particular are vital to women in Medicaid.

- Medicaid covers nearly 40% of all births in the U.S.
- The program contributed \$770 million toward family planning in 2001, making it the largest source of public funding for family planning in the U.S.

While Medicaid provides health care coverage for a substantial number of low-income women, many go without coverage.

- Expanded access to comprehensive health care and insurance is particularly important to low-income women because of their higher rate of health problems and inadequate resources.
- Despite efforts to provide coverage to low-income women through state expansions, 17.7 percent of women ages 18 to 64 remain uninsured. Over thirty-five percent of women with incomes below 200 percent of FPL lack health insurance.

Cuts to Medicaid Will Hurt U.S. Women

Federal and State Reforms to Medicaid Amount to Drastic Cuts

Medicaid is a vital source of insurance for millions of low-income Americans. The program currently provides health insurance coverage to nearly 55 million parents, children, pregnant women, elderly and people with disabilities. For those individuals that qualify, who are the poorest among us, Medicaid provides coverage for a panoply of important health care services, including physician and hospital care, preventive screenings, pregnancy-related care, contraceptive coverage and long-term care services. Medicaid provides these services in an efficient manner; in the wake of a health insurance market that has seen dramatically rising costs, Medicaid's costs have grown at *half the rate* of private insurers.¹

Yet, policy makers on both the federal and state levels have called for "reforms" to the Medicaid program. President Bush has consistently supported limiting funding for the Medicaid program and has even proposed capping federal funding to the states. Congress has followed with major legislative changes that allow states to limit benefit packages and charge beneficiaries more for their care. Some states have applied to the federal government for very broad waivers in order to get out of certain federal requirements that guarantee benefits and restrict cost-sharing. The loss of these federal protections leaves many beneficiaries vulnerable to severe benefit reductions, high out of pocket costs and even removal from the program.

Why Do These Cuts Matter to U.S. Women?

Medicaid provides vital health care services to low-income women, who comprise 71% of beneficiaries age 19 and older.² Women are *twice* as likely as men to qualify for Medicaid because they are poorer and more likely to meet the stringent eligibility criteria and because they are in lower paying jobs that are less likely to come with employer-sponsored insurance. Health insurance is critical to women because mothers with health insurance are more likely to stay employed and get health care for their children than those lacking insurance.

Women Rely on Medicaid for a Range of Services

- *Very low-income parents* with dependent children can get comprehensive services if they have incomes below a certain percentage of the federal poverty level.³ Income limits vary by state. The income limit for working parents ranges from 18% of FPL (about \$254 a month for a family of three) to 267% of FPL (about \$3,690 a month for a family of three). The median income limit is 67% of FPL.⁴ These services help keep these women healthy, which allows them to take care of their families and remain in the workforce.

¹ John Holahan and Arunabh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

² Kaiser Commission on Medicaid and the Uninsured analysis of 2001 MSIS data.

³ All references to the federal poverty level (FPL) are for 2006 levels for the 48 continuous states and DC. Please note that Hawaii and Alaska have higher FPLs. Federal Poverty Guidelines are available at <http://aspe.hhs.gov/poverty/06poverty.shtml>

⁴ Donna Cohen Ross and Laura Cox, "In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families." Table 3, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, October 2005. Available at <http://www.kff.org/medicaid/upload/In-a-Time-of-Growing-Need-State-Choices-Influence-Health-Coverage-Access-for-Children-and-Families-Report.pdf>

- *Low-income pregnant women* can get prenatal care if they fall under state-specified income limits. Income limits for pregnant women range from 133% of FPL (about \$1,086 a month for an individual) to 275% of FPL (about \$2,246 a month for an individual). The median income limit is 185% of FPL. **In the U.S., nearly 40% of all births are paid for by Medicaid.**⁵
- *Low-income disabled and aged people* are eligible for Medicaid if they meet certain income levels, which vary by state, ranging from 64% of FPL (about \$523 a month for an individual) to 100% of FPL (about \$817 a month for an individual). The median income limit is 74% of FPL. These beneficiaries rely on Medicaid for both comprehensive care and long-term services, the latter of which are extremely costly and can have a devastating financial impact on women with fixed incomes. Medicaid is the largest source of funding for people in nursing homes, who tend to be women over 80 without a spouse or close relative living in their community.
- *Low-income women who have breast and cervical cancer* and who are diagnosed through the CDC screening program can receive treatment for their illness if they are under 65 and their income meets the level determined by the state in which they reside. Income limits range from 185% FPL (about \$1,511 a month for an individual) to 312% FPL (about \$2,548 a month for an individual). The median income limit is 250% FPL.
- *Low-income women in need of family planning* can receive these services if they are eligible for Medicaid. Family planning, a mandatory service under Medicaid, generally covers major prescription contraceptive methods, gynecological care, sterilization, and testing for and treatment of sexually transmitted diseases. Twenty-one states have waivers that expand coverage of family planning only to low-income women who would otherwise not qualify for Medicaid.⁶

States Depend on the Federal Government for a Significant Share of Program Costs

The Medicaid program is run jointly by the federal, state and county governments. The federal government contributes a share of the program's costs, based on the per capita income in the state. Total federal Medicaid costs for the program in 2005 were more than \$183 billion.⁷

Medicaid Is Cost Effective

Medicaid is more efficient than traditional private health insurance programs. Medicaid spends 30% less per adult than private coverage.⁸ Also, Medicaid costs have been growing at slightly more than half the rate of the cost of private insurance,⁹ despite the fact that Medicaid faces increased enrollment during weak economic times.

⁵ MCH Update: States Protect Health Care Coverage during Recent Fiscal Downturn, National Governors Association, Table 1, Draft 8/11/05. Available at <http://preview.nga.org/Files/pdf/0508MCHUPDATE.PDF>.

⁶ Guttmacher Institute, "Medicaid Family Planning Waivers," *State Policies in Brief* (January 2006).

⁷ Medicaid costs are calculated by totaling the projected state costs listed in individual state fact sheets, available at the Families USA Medicaid Action Center, http://www.familiesusa.org/site/PageServer?pagename=Medicaid_Action.

⁸ Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, Winter 2003/2004.

⁹ John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-20003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003, available at <http://www.kff.org/insurance/ehbs2003-abstract.cfm>.

Medicaid and Minority Communities: Why Medicaid is So Important

Racial and ethnic minorities are projected to make up almost half of the U.S. population by the year 2050. Unfortunately, there are significant health disparities for minority populations in the US. Although there are many different reasons for minority health disparities, access to insurance is one of the most important pieces of the puzzle. The landmark Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Care* provides compelling evidence that *access to care* is the real key to closing the gap in health outcomes for all racial and ethnic groups. According to the report, ***the single most effective way to reduce racial and ethnic disparities in health is through the expansion and preservation of public programs like Medicaid.***

Medicaid is currently the largest source of health care funding for the poor in the U.S., serving one in six Americans or close to 53 million people.¹ Medicaid guarantees eligible individuals coverage for primary, acute and long-term care services. The program is run jointly by the federal and state governments, with each state administering its own Medicaid program under federal guidelines, and the federal government contributing more than half of the program's costs.² It is a vital safety net health insurance program that provides access to health care for the most vulnerable Americans, many of whom are racial and ethnic minorities.

Disparities in Health

The list of health disparities for minorities' health is long. African Americans, Latinos and American Indians are more likely to rate their health as fair or poor in comparison to whites.³ Rates of diseases such as cancer, cardiovascular disease, diabetes, tuberculosis and HIV/AIDS are higher for some or all racial and ethnic minorities. African American women, for example, have the highest rate of death from heart disease, breast and lung cancer, stroke, and pregnancy compared to women of all other racial and ethnic backgrounds.⁴

Disease and Conditions	White	Black	Hispanic	Asian American/Pacific Islander	American Indian/Alaskan Native	Other
Obesity	55.3%	65.8%	57.6%	35.9%	61.6%	54.3%
Mental Health	33.6%	34.4%	34.7%	31.3%	36.8%	41.4%
HIV/AIDS Distribution of reported cases	40.1%	39.9%	18.7%	0.8%	0.3%	0.2%

Note: All data was obtained from the Kaiser Family Foundation database *State Health Facts online* available at <http://www.statehealthfacts.org>

¹ IssuesPA, *Medicaid 101 – An Overview of a Federal-State Partnership*. at <http://www.issuespa.net/articles/10933/> (accessed June, 2005).

² National Health Policy Forum, *The Basics: Medicaid Financing*. The George Washington University, September 14, 2004. at http://www.nhpf.org/pdfs_basics/Basics_MedicaidFinancing.pdf

³ FamiliesUSA, Quick Facts: Disparities in Health, Minority Health Initiatives, January 2006.

⁴ *Making the Grade on Women's Health: A National and State By State Report Card* (Washington: National Women's Law Center, May 2004).

Disparities in Health Coverage

Racial and ethnic minorities make up one-third of the US population, but comprise 52% of the uninsured.⁵ Lack of health insurance is a significant barrier to obtaining medical services – a barrier that invariably leads to less care and worse health outcomes for many. In particular, the lower rates of employer-sponsored insurance for racial and ethnic minorities are striking.

Although 70 percent of whites are insured through an employer-sponsored health plan, less than half of African Americans and Hispanic – the two largest US racial and ethnic minorities – had such coverage in 2003.⁶

Insurance Coverage	White	Black	Hispanic	Other
Employer-Sponsored	69%	48%	40%	59%
Medicaid	9%	25%	22%	13%
Uninsured	13%	21%	34%	19%

Note: All data was obtained from the Kaiser Family Foundation database *State Health Facts* online available at <http://www.statehealthfacts.org>

Policy Solutions: Medicaid is Paramount

Public programs, specifically Medicaid, hold the greatest promise for helping to mitigate health disparities for racial and ethnic minorities. Medicaid covers half of African Americans below poverty and one in four Latino and Asian American/Pacific Islander children. The program is particularly important for these populations because of their higher rates of poverty.⁷ In fact, during the 2000 economic recession, which hit African Americans particularly hard, Medicaid played an important safety role by keeping workers who lost their jobs, and their job-based coverage, insured.

Medicaid has the potential to do even more to keep and expand health care coverage for minorities in the U.S. Nearly 8 in 10 uninsured African American children appear to be eligible for Medicaid and SCHIP but are not enrolled so improving enrollment procedures and outreach will help reduce the number of uninsured.⁸ It is estimated that 74 percent of the 23 million uninsured minority Americans could be covered using Medicaid and SCHIP.⁹

The Medicaid program has faced severe challenges in the last year. The federal Deficit Reduction Act of 2005 cut Medicaid funding and also allowed for changes to the program that have already resulted in decreased benefits and higher costs for some beneficiaries.¹⁰ States, on their own, have reduced benefits to enrollees and even cut thousands of individuals from the program altogether. It is important that cuts to this federal-state program be stopped and, ideally, reversed as Medicaid provides vital health care to millions of individuals.

⁵ (2003) Kaiser, March 2005

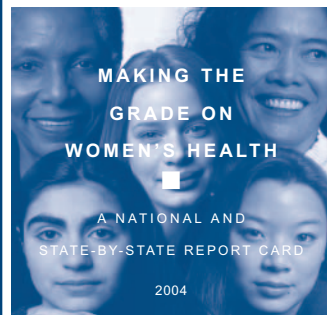
⁶ US Census Bureau, "Health Insurance Coverage: 2004," *Current Population Survey 2004*

⁷ For example, African Americans are three times more likely to be in poverty and half of all African American families have family incomes less than 200% FPL. Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage and Access to Care Among African Americans*, The Kaiser Family Foundation, June 2000.

⁸ *Going Without: America's Uninsured Children* Washington: Robert Wood Johnson Foundation, August 2005

⁹ *FamiliesUSA, Improve Public Programs Improve Minority Health*, January 2006

¹⁰ For more information on the effects of the Deficit Reduction Act, please see *Medicaid Cuts: Benefits May Be Reduced for Women* at http://www.nwlc.org/pdf/FSMedicaidandtheDRA_04.21.06.pdf



Making the Grade on Women's Health: A National and State-by-State Report Card, 2004

Fact Sheet: Racial and Ethnic Disparities among U.S. Women

Making the Grade on Women's Health: A National and State-by-State Report Card assesses the overall health of women at the national and state levels by examining 34 indicators of women's health status and 67 state policies that can contribute to improving women's health. Below are highlights on the disparities in health care among U.S. women.

Racial and Ethnic Health Disparities among U.S. Women

The nation is becoming increasingly diverse, with ethnic and racial minorities projected to make up almost half the population by the year 2050. Despite this increasing diversity, the health care system has not kept pace and women of color in the United States often face obstacles in obtaining appropriate health care. Some of these problems may be due to linguistic and logistical barriers, cultural differences, and race and sex-based stereotypes. There are also marked differences in health status among different groups of women of color. This fact sheet compares women of different racial and ethnic groups in their health risk factors; screening, incidence and mortality rates for certain diseases and conditions; issues related to pregnancy; and socioeconomic characteristics.

White Women: White women have the lowest rates for unintended pregnancy, maternal mortality, and poverty. They also have the lowest mortality rates for cervical cancer. Moreover, they have the lowest percentage of uninsured women and the highest percentage of those who report engaging in leisure-time physical activity, apart from Pacific Islander women. White women are also the most likely to obtain first trimester prenatal care and mammograms. White women have the highest rates for breast cancer incidence and lung cancer mortality. They have the second highest mortality rates for coronary heart disease and stroke.

Black Women: Black women have the highest rate of obtaining Pap smears, the second highest rate for mammograms, and the lowest prevalence of osteoporosis. However, Blacks have the

shortest life expectancy, the highest poverty rate, are least likely to get prenatal care, and are most likely to be obese. Black women fare the worst in mortality rates for coronary heart disease, stroke, and diabetes, and in incidence rates for AIDS and lung cancer. They also have the highest rates of unintended pregnancy, infant mortality, and maternal mortality.

Hispanic/Latina Women: Hispanics have the lowest stroke mortality rate. On the other hand, as the second least likely group to have been screened for cervical cancer in the last three years, Hispanics fare worse than other groups of women in cervical cancer incidence and mortality. They have the highest percentage of uninsured women and the second highest AIDS incidence rate. Hispanic women have the highest percentage of no leisure-time physical activity.

American Indian/Alaskan Native Women: Native American women have the second lowest stroke mortality rate. However, Native American women fare the worst of all groups for smoking, binge drinking, cirrhosis mortality rate, and violence against them.

Asian American/Pacific Islander Women: Asian American women fare best in the preventive health behaviors of avoiding obesity and smoking. Asian American/Pacific Islander women have the lowest incidence rate for AIDS, the lowest infant mortality rate, lowest mortality rates for coronary heart disease and breast cancer, and the second lowest mortality rate for lung cancer. Asian American women are disproportionately affected by cervical cancer and are the least likely to have had a Pap smear within the last three years.

Top Five Causes of Death among U.S. Women by Race and Ethnicity

(mortality rates per 100,000 population)

White	Black	American Indian/ Alaskan Native	Asian American/ Pacific Islander	Hispanic/Latina
Coronary Heart Disease (151.0)	Coronary Heart Disease (203.9)	Coronary Heart Disease (102.6)	Coronary Heart Disease (91.8)	Coronary Heart Disease (134.4)
Stroke (56.7)	Stroke (75.6)	Diabetes (45.6)	Stroke (49.3)	Stroke (42.6)
Lung Cancer (41.9)	Diabetes (49.2)	Stroke (44.4)	Lung Cancer (19.4)	Diabetes (35.9)
Chronic Lower Respiratory Diseases (39.7)	Lung Cancer (39.6)	Unintentional Injuries (35.0)	Diabetes (16.3)	Influenza and Pneumonia (17.3)
Breast Cancer (26.0)	Breast Cancer (34.8)	Chronic Lower Respiratory Diseases (27.8)	Influenza and Pneumonia (15.0)	Chronic Lower Respiratory Diseases (17.0)

Source: National Center for Health Statistics, "Healthy Women: State Trends in Health and Mortality," available at <http://www.cdc.gov/nchs/healthywomen.htm>, accessed January 20, 2004. Rates are three-year averages from 1999-2001. Death rates for all ages include deaths occurring at any age, and are age-adjusted to the U.S. 2000 standard population.

Information in this fact sheet is drawn from *Making the Grade on Women's Health: A National and State-by-State Report Card 2004*, prepared by the National Women's Law Center and Oregon Health & Science University. The full report is available for download or purchase from www.nwlc.org.

Health Status Indicators for U.S. Women by Race and Ethnicity

Women are more likely to be healthy if they get screenings, reduce or avoid unhealthy behaviors, and have health insurance. The chart below describes these factors by race and ethnicity. It also describes how well each group fares in disease incidences and death. It is interesting to note that for some diseases (for example breast cancer), Black women have a higher death rate than do White women, even though Blacks have a lower incidence rate for breast cancer. Further research needs to be done to determine the reasons for racial and ethnic health disparities among women and the policies that can best eliminate those disparities and improve the health of all women.

	White (All)	Black (All)	American Indian/ Alaskan Native (All)	Asian American / Pacific Islander (All) ¹	Hispanic (All)
Demographic Data					
Population of Females (number) ^{2,3}	99,802,682	18,728,044	1,470,805	6,380,042	18,752,473
Population of Females (%) ^{2,3}	68.8	12.9	1.0	4.4	12.9
Risk Factors and Unhealthy Behaviors					
No Leisure-Time Physical Activity (%) ^{2,3}	38.3	55.1	55.5	42.6/27.1	57.5
Obese (%) ^{6,5}	19.8	34.9	29.7	6.2/23.9	25.5
Smokers (%) ^{7,5}	22.2	19.5	34.5	6.7/26.8	10.6
Binge Drinkers (%) ^{8,5}	12.9	5.5	17.3	4.2/14.7	6.8
Diseases and Conditions⁹					
Cardiovascular Health					
Coronary Heart Disease Mortality Rate	151.0	203.9	102.6	91.8	134.4
Stroke Mortality Rate	56.7	75.6	44.4	49.3	42.6
Lung Cancer					
Lung Cancer Incidence Rate ¹⁰	51.9	54.8	23.4	28.4	24.4
Lung Cancer Mortality Rate	41.9	39.6	26.8	19.4	14.7
Breast Cancer					
Mammograms (%) ^{10,11}	72.1	68.2	52.0	57.0	62.6
Breast Cancer Incidence Rate ¹⁰	140.8	121.7	58.0	97.2	89.8
Breast Cancer Mortality Rate	26.0	34.8	13.5	12.7	16.7
Cervical Cancer					
Pap Smears (%) ^{10,12}	83.9	85.5	78.4	68.2	77.9
Cervical Cancer Incidence Rate ¹⁰	9.2	12.4	6.9	10.2	16.8
Cervical Cancer Mortality Rate ¹⁰	2.7	5.9	2.9	2.9	3.7
Diabetes Mortality Rate	20.4	49.2	45.6	16.3	35.9
AIDS Incidence Rate ¹³	2.4 ³	47.8 ³	4.9	1.5	12.9
Reproductive Health					
Unintended Pregnancies (%) ¹⁴	42.9	72.3			48.6
First Trimester Prenatal Care (%) ¹⁵	85.4	75.2			76.7
Infant Mortality ¹⁶	5.7	13.6	9.1	4.8	5.6
Maternal Mortality ¹⁷	5.3	19.3			
Socioeconomic Characteristics					
Uninsured (%) ^{3,18}	12.0	21.0	27.2	20.3	36.9
Poverty (%) ^{3,19}	8.8	22.8	21.4	10.0	21.2

Sources and Notes for Chart:

Unless otherwise noted, data on this chart are from *Making the Grade on Women's Health: A National and State-By-State Report Card* (Washington: National Women's Law Center, 2004, pages 8-9).

¹ If two numbers are presented, the first applies to Asian Americans, the second to Pacific Islanders. Otherwise, data refer to all women classified as Asian/Pacific Islander.

² Number and percentage of females of all ages as a percentage of the total civilian, non-institutionalized population, 2002-2003.

³ No women who were counted as Hispanic were also counted in other groups (e.g., Whites included only non-Hispanic Whites).

⁴ No leisure-time light, moderate, or vigorous physical activity, 1999-2001.

⁵ Charlotte Schoenborn and others, National Center for Health Statistics, *Health Behaviors of Adults: United States, 1999-2001* (Hyattsville: U.S. Department of Health and Human Services, February 2004), 68 (citing National Health Interview Survey, women age 18 and older in all groups except U.S. overall, age-adjusted to 2000 U.S. standard population).

⁶ Body Mass Index (BMI) greater than 30 kg/m²; age 20 and older, 1999-2001.

⁷ Women age 18 and older who report having smoked at least 100 cigarettes in their lifetime and smoking currently (every day or only some days), 1999-2001.

⁸ Five or more drinks in one day at least once within the past year, 1999-2001.

⁹ Unless otherwise indicated, incidence and mortality rates are per 100,000 women of all ages, averaged from 1999-2001, and age-adjusted to the 2000 U.S. standard population.

¹⁰ American Cancer Society, *Cancer Facts and Figures 2004* (Atlanta: American Cancer Society, 2004), 23-28 (citing National Health Interview Survey 2000, National Center for Health Statistics), age-adjusted to the 2000 U.S. population; citing SEER Cancer Statistics Review, 1975-2000, National Cancer Institute, available at http://seer.cancer.gov/csr/1975_2000/results_merged/topic_race_ethnicity.pdf, accessed April 1, 2004, rates per 100,000 population, 1996-2000, and age-adjusted to the 2000 U.S. standard population. Incidence data are from the 12 SEER areas: San Francisco, Connecticut, Detroit, Hawaii, Iowa, New Mexico, Seattle, Utah, Atlanta, San Jose-Monterey, Los Angeles, and Alaskan Native Registry. Mortality data are from all states except Connecticut, Oklahoma, New York, and New Hampshire.

¹¹ Mammography prevalence in women age 40 and older (within 2 years), 2000.

¹² Pap test in women age 18 and older (within 3 years), 2000.

¹³ Female adult/adolescent (age 13 and older) annual AIDS rates per 100,000, for cases reported in 2000.

¹⁴ Women ages 15-44 who had an unintended pregnancy in 1994.

¹⁵ Mothers who reported on their child's birth certificate that they received prenatal care in the first trimester of pregnancy (2002).

¹⁶ Per 1,000 live births (1999-2001).

¹⁷ Per 100,000 live births (1987-1996).

¹⁸ Women ages 18-64 in the non-institutionalized civilian population who report that they do not have health insurance (2001-2002).

¹⁹ Women age 18 and older whose family income level falls below the federal poverty threshold (2001-2002).

Medicaid Cuts: Benefits May Be Reduced for Women

The Deficit Reduction Act of 2005 (DRA) allows states to avoid federal requirements governing which services certain groups of beneficiaries receive through Medicaid. This could have some especially troubling effects for women's health as they face the possibility of losing key benefits, including family planning services.

Medicaid Eligibility

Only certain, limited groups, subject to particular income and resource eligibility levels, are eligible for Medicaid insurance. These are: (1) Children, (2) Parents, (3) Pregnant Women, (4) People with Disabilities, and (5) the Elderly. Women make up 71% of adult Medicaid beneficiaries, and 11.5% of U.S. women of reproductive age (15-44) are covered by the program.¹

Before the DRA: Certain Benefits Were Required for Everyone

Before the DRA, there were certain federal Medicaid requirements, known as **mandatory services**, that had to be provided, when medically necessary, to all Medicaid beneficiaries. These included: *physician and hospital services, laboratory and x-rays, early and periodic screening, diagnostic, and treatment (EPSDT) services for defined children, federally-qualified health center services, family planning, pediatric and family nurse practitioner services, nursing facility services for individuals 21 and older and home health care*. Although the states had discretion in the amount, duration and scope of this coverage,² coverage for these mandatory services had to be provided.

States also could receive federal funds to cover certain non-mandatory services. These **optional benefits** have included important services such as prescription drugs, dental treatment and physical therapy and currently represent 60% of all Medicaid expenditures. *Notably, once a state decides to cover a service, it generally must offer the service to all Medicaid beneficiaries regardless of eligibility group.*

After the DRA: Parents and Children May Be Enrolled in Reduced Benefit Plans

Under the DRA, states can replace their traditional Medicaid plans with so-called "benchmark" plans, which are reduced benefit packages. However, states cannot require certain groups to use a benchmark plan rather than a traditional Medicaid plan. These exempted populations include pregnant women at or below 133% of FPL, elderly, blind and disabled individuals and women

¹ Adam Sonfield and Rachel Benson Gold, "Conservatives' Agenda Threaten Public Funding for Family Planning." *The Guttmacher Report* February 2005.

² For example, they can limit the number of physician visits per year or the length of stay for a hospital visit.

battling breast or cervical cancer, leaving *parents*³ *and children*⁴ as the only Medicaid-eligible populations who can be required to use the new state benchmark plans rather than traditional Medicaid.

Unfortunately, CMS, the agency responsible for overseeing Medicaid, has interpreted the DRA to allow states to enroll *all Medicaid beneficiaries* in benchmark plans, so long as the enrollment is voluntary and the exempt groups may “opt out” at any time and go back to traditional Medicaid coverage. Of course, *“opting out” requires that beneficiaries know that their participation is voluntary and that they understand how to opt out if they choose to do so.*

Reduced Benefit Plans are a Big Step Backward from Traditional Medicaid

Benchmark plans are not subject to traditional Medicaid requirements. Instead, they are only required to offer benefits equivalent to those offered in either (1) the Federal Employee Health Benefits Program⁵, (2) the state’s own state employee health benefits plan⁶, (3) the HMO with the largest non-Medicaid enrollment in the state,⁷ (4) the actuarial equivalent of one of these plans,⁸ or (5) whatever package the state designs that would be “appropriate for the population” so long as it is approved by the Secretary of Health and Human Services.

States opting for a benchmark plan will do so in order to cut costs by reducing benefits below the requirements of traditional Medicaid. In fact, *the Congressional Budget Office (CBO) estimates that benefit reductions resulting from the benchmark option will reduce spending on parents by one-third.*

Under the DRA, in addition to avoiding coverage requirements, states may now ignore the long-standing requirement under Medicaid law that benefit packages be “comparable” across groups of eligible people, and states can now design different packages for different groups of people. Thus, a parent in a benchmark plan could be offered a different benefit packages than his/her child, and a state could even vary packages across different regions in the state.

The DRA Compromises Family Planning Services for Women

Given the leeway to ignore longstanding Medicaid benefit requirements as well as the ability to create different coverage for different groups, the benchmark plans may result in a *significant reduction in services for parents and children.*

It is hard to know exactly which benefits will be lost, but states have already had the “flexibility” to design packages for SCHIP based on the same benchmark options now given to states for their

³ Because of confusing guidance issued by CMS about the DRA, it is uncertain whether any parents will be exempted.

⁴ In an effort to preserve EPSDT, the DRA requires that children in benchmark plans also have a “wrap-around” plan to cover additional services when the benchmark plan doesn’t cover all of the EPSDT services. Unfortunately, this is likely to create an administrative hurdle that will make it harder for children to get the comprehensive care to which they are entitled.

⁵ The standard Blue Cross/Blue Shield preferred provider plan that the federal government offers its employees.

⁶ Any health benefit plan that a state provides its employees.

⁷ States can also determine the value of the benefits offered in these plans and offer a plan with the same value (known as an actuarial equivalent plan).

⁸ This is referred to in the DRA as “benchmark equivalent coverage.”

Medicaid plans under the DRA. In designing the SCHIP plans, *four states* - Montana, North Dakota, Pennsylvania and Texas - *chose packages that do not include coverage of family planning*. Also, North Dakota, and Wyoming do not cover contraceptives in their state employee health plan, and North Dakota's largest HMO does not cover family planning in its benefit packages. Taking this information together, it is clear that *the DRA puts key family planning services at risk*.

Birth control is the main component of family planning coverage under Medicaid and a vital health care service. It is the most effective way to prevent unwanted pregnancies and safely space pregnancies in the interest of the mother's and child's health. Other services important to women are potentially at risk, including the very few abortions that are allowed to be covered under Medicaid.⁹

Conclusion

Ultimately, the DRA gives states unprecedented flexibility to the states through so-called "benchmark" plans to cut any benefit. The primary target of these reduced benefit packages will be low-income parents, the majority of whom are women. Parents who qualify for Medicaid are among the poorest individuals; the average income of such a beneficiary is under \$11,000 a year for a family of three. Limiting benefits to this population will surely result in a loss of care for many low-income women and their families.

⁹ Coverage of abortion under Medicaid is very limited. Federal law - known as the Hyde amendment - requires that Medicaid dollars be used to cover abortions only in cases of rape or incest or if the woman's life is endangered. States can, and many do, cover more abortions without federal dollars.

Increased Cost-Sharing in Medicaid Hurts Women and Their Families

New flexibility granted to the states under the Deficit Reduction Act (DRA) allows for increased cost-sharing as a way to contain program costs. This has real implications for the access to care and health status of low-income populations. *A working mother with two children is eligible for Medicaid only if she makes, on average, \$309 or less a week.* On this sort of budget, a family would be hard-pressed to find the resources to pay a co-payment if in need of medical care.

Thus, cost-sharing measures reduce costs by making necessary health care unaffordable.¹

Also, cost-sharing policies ultimately increase financial burdens on other parts of the health care system by forcing beneficiaries to delay care until they are sicker and wind up in the emergency room.

What is Cost-Sharing?

Cost-sharing refers to the out-of-pocket payments, usually in the form of co-payments, that beneficiaries are required to make in connection with the receipt of a covered service under their health insurance plan. The majority of states use co-payments – fixed amounts that must be paid by the beneficiary at the time the service is received – as their primary cost-sharing device. Some states also impose premiums, which are prepaid payments made to a health plan by beneficiaries.²

Before the DRA, Cost-Sharing in Medicaid Was Limited

Prior to the DRA, Medicaid law forbade cost-sharing for certain populations and for select services. No co-payments were allowed for children under age 18, terminally ill individuals in hospices, inpatients in nursing facilities³, services for pregnant women and family planning, or for emergency services. For all other populations and services, states were allowed to impose “nominal” cost-sharing.⁴

Also, federal law prohibited participating physicians, hospitals, and other providers from collecting additional payments from their patients. Thus, providers had to serve a Medicaid patient, even if the person cannot pay the required cost-sharing.⁵

¹ Cindy Mann and Samantha Artiga, “The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon’s Medicaid Program.” Kaiser Commission on Medicaid and the Uninsured, June 2004.

² Like traditional cost-sharing, premiums require an out-of-pocket cost to beneficiaries and therefore have many of the same effects of cost-sharing. Andy Schneider et al. “The Medicaid Resource Book.” Kaiser Commission on Medicaid and the Uninsured, July 2002, p 62.

³ This restriction applies to those inpatients in hospitals and nursing homes that are required to apply most of their income to the cost of their care. *Id.*, p 64.

⁴ *Id.*, p64. (Nominal cost-sharing is defined as \$2 per month per family for a deductible, between \$.50 to \$3.00 for co-payments, and a five percent coinsurance of the state’s payment rate for the item or service.)

⁵ Even though the provider can’t withhold the service, the patient is still liable to the provider for the allowable cost-sharing amount.

After the DRA: Most Beneficiaries Face Cost-Sharing

The DRA allows states to impose new or higher cost sharing on most Medicaid beneficiaries. Cost-sharing can be imposed in the following ways:

- Children and parents over 150% of FPL can be charged unlimited premiums and co-payments of up to 20% of the cost of the service.
- Children and parents between 100% of FPL and 150% of FPL can be charged co-payments up to 10% of the cost of the service.
- Total cost sharing (including both co-payments and premiums) can be up to 5% of an individual's income determined on a quarterly or monthly basis.
- No eligible individual is exempt from co-payments on non-preferred prescription drugs
- Mandatory children and pregnant women⁶ are prohibited from cost-sharing except for co-payments for non-preferred prescription drugs.

The DRA also allows states to adjust the “nominal” amount annually according to medical inflation. More significantly, the DRA grants providers the right to *deny* services or drugs if a beneficiary cannot pay the cost-sharing amount at the point of service. This individual not only faces a loss of care for a particular health need, but also faces the loss of his/her health insurance all together. The DRA states that if a person does not pay his/her premium within 60 days of the due date, the state can terminate the person's enrollment. Beginning in January 2007, states can also allow hospitals to impose cost-sharing on non-emergency use of the ER.

Cost-Sharing Hurts Low-Income Populations

Co-payments are intended to limit the overuse of health care. However, particularly with low-income populations, the result of imposing co-payments goes beyond limiting overuse. ***Research shows that co-payments cause patients to avoid or delay essential medical care, and premiums lead many to drop out of publicly funded health insurance programs all together.*** One comprehensive study found that low-income adults and children reduced their use of *appropriate* medical care services by 44% when they were forced to make co-payments.⁷ This study also found that co-payments lead to poorer health among low-income adults as compared to those not subject to this form of cost-sharing.

Similarly, premiums reduce low-income people's access to care. One multi-state study showed that ***premiums set as low as 1% of family income led to a 15% reduction in participation in publicly funded health insurance programs, while a 3% premium led to almost a 50% decrease in enrollment.***⁸

The consequences of all types of cost-sharing can be especially serious for Medicaid beneficiaries because they have severely limited financial means and already bear a large out-of-pocket burden for their health expenses. On average, non-elderly, non-disabled adults on

⁶ Mandatory children are those ages 0-5 at or below 133% of FPL and ages 6-19 at or below 100% of FPL. Mandatory pregnant women are women at or below 133% of FPL.

⁷ Leighton Ku, “Charging the Poor More for Health Care: Cost-Sharing in Medicaid.” Center on Budget and Policy Priorities, May, 7, 2003 (citing the 1992 The Rand Health Insurance Experiment, <http://www.rand.org/health/hiedescription.html>).

⁸ Leighton Ku, “The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings.” Center on Budget and Policy Priorities, May 31, 2005.

Medicaid with incomes below the federal poverty level spend *three times* as much (by percentage of income) on out-of-pocket payments than the amount spent by middle-class adults with private coverage.⁹ Also out-of-pocket medical expenses for non-elderly, non-disabled adult Medicaid beneficiaries grew *twice as fast* as their income.¹⁰

Cost-Sharing Will Hurt the Health of Women and their Families

The findings from Oregon and Utah along with an abundance of other studies¹¹ on the effects of co-payments and premiums on low-income populations point to the fact that increased cost-sharing in Medicaid:

- makes participation in publicly-funded health coverage like Medicaid unaffordable;
- prevents access to primary and preventive care;
- leads to poorer health outcomes for low-income families;
- leads to more complicated health conditions that require more expensive care and greater inappropriate use of the emergency room; and
- increases both the rate of uncompensated care and the pressure on safety-net providers.

Women and their families do not fare well when costs for Medicaid coverage and care exceed their ability to pay, leaving many uninsured and with unmet medical needs. Although cost-sharing rates have not increased since the 1980s, neither has the amount of income that a family is allowed to have in order to qualify for the Medicaid program in many states. In fact, in most states, Medicaid covers only the very poorest parents. Imposing more cost-sharing on these populations simply would force many to go without care.

⁹ Leighton Ku and Matthew Broaddus, "Out-of-Pocket Medical Expenses for Medicaid Beneficiaries are Substantial and Growing." Center on Budget and Policy Priorities, May 31, 2005.

¹⁰ For those below the poverty line, out-of-pocket payments grew by an average of 9.4% per year from 1997 to 2002, while over the same period of time, income grew only 4.6% annually. Ku and Broaddus.

¹¹ For a review of the research, see Julie Hudman and Molly O'Malley, "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations." Kaiser Commission on Medicaid and the Uninsured, March 2003.

The DRA Imposes Burdensome Documentation Requirements on US Citizens

The Deficit Reduction Act of 2005 (DRA) imposes new citizenship documentation requirements for Medicaid eligibility that increase the likelihood that U.S. citizens will face delay, denial or loss of Medicaid coverage.

Before the DRA: Documentation Not Required to Verify Citizenship for Eligibility

All U.S. citizens who meet Medicaid's financial and non-financial eligibility criteria are entitled to Medicaid, though certain legal immigrants are also eligible. The federal government has long required states to establish that Medicaid applicants are U.S. citizens or satisfy the immigration restrictions. Prior to the DRA, states could determine citizenship by allowing applicants to attest to their citizenship in writing. All states except Montana, New Hampshire, New York and Georgia used this self-declaration option to establish U.S. citizenship.

After the DRA: Strict Documentation Requirements Enacted

The DRA adds new documentation requirements for establishing eligibility. Effective July 1, 2006, citizens applying for or renewing their Medicaid coverage must prove their citizenship by providing documents such as birth certificates or U.S. passports. Individuals are required to provide originals or certified copies of these documents which may be time-consuming and costly. Some states may be able to utilize electronic matches of vital records for individuals who lack paper citizenship documents and who still reside in the state in which they were born; however, there are no interstate vital records databases yet. Because states are not permitted to provide applicants with coverage while they attempt to obtain the necessary documents, individuals may experience serious delays while securing these documents. Disabled beneficiaries who also receive Medicare or SSI benefits are exempt from the new requirement.

Who Will be Affected?

- Between 1.2 and 2.3 million U.S.-born citizens may have serious problems getting or retaining Medicaid coverage because they lack a birth certificate or passport.¹
- Those most likely to be affected are low-income children and parents who are citizens and otherwise eligible for Medicaid, but who lack a birth certificate or passport.
- In addition, while most disabled Medicaid beneficiaries are exempt from the new requirement because they also receive Medicare or SSI benefits, an estimated 750,000 people with disabilities are not exempt and will be required to submit documentation.²
- Some populations are particularly vulnerable. For example, birth certificates are costly and may be difficult for some low-income populations to obtain.
- This provision will likely have a negative impact on people of color and the rural poor. For example, during much of the 20th Century in the South, access to hospitals for births

¹ Leighton Ku, Center on Budget and Policy Priorities, "Revised Medicaid Documentation Requirement Jeopardizes Coverage for 1 to 2 Million Citizens," July 13, 2006.

² Ibid.

were limited to African-American and poor white families. As a result, members of these groups were born at home and do not have birth certificates.³

- Other groups likely to incur problems include foster children, Native Americans, the homeless, and survivors of Hurricane Katrina.⁴

Family Planning Expansion Populations

Individuals who receive family planning services under Medicaid waivers may be significantly impacted by the new documentation provision. Twenty-five states have obtained waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy.⁵ Because these individuals become Medicaid beneficiaries for coverage of family planning services and supplies only, they typically enroll on site at family planning clinics instead of applying at public assistance offices. Clinics are not equipped to deal with the burdensome documentation requirements which may lead to confusion, delays and even denials of care. In addition, the time-sensitive nature of family planning services make the DRA's impact particularly troublesome for this population.

³ Jane Perkins, National Health Law Program, "The Deficit Reduction Act of 2005: Implications for Advocacy," Apr. 27, 2006.

⁴ The Henry J. Kaiser Family Foundation, "New Requirements for Citizenship Documentation in Medicaid," *Medicaid Facts*, July 2006.

⁵ AL, AZ, AR, CA, DE, FL, IL, IA, LA, MD, MI, MN, MO, NM, NY, NC, OK, OR, RI, SC, TX, VA, WA, & WI currently have family planning waivers. "State Medicaid Family Planning Eligibility Expansions" *State Policies in Brief*, The Guttmacher Institute, December 2006.

Medicaid, Birth Control and Women's Health

Medicaid is the joint federal/state health insurance program for certain categories of the poorest among us. The program is of particular importance to women, who make up 71% of the program's adult insured. Within this group, approximately 7 million women of reproductive age rely on Medicaid for their health insurance.¹

From the Nixon administration until the passage of the Deficit Reduction Act this year, "family planning services"² were clearly specified as a mandatory benefit under Medicaid. Then, as now, there was the widespread understanding that birth control, the main component of family planning coverage, was the most effective way to (1) prevent unwanted pregnancies, (2) safely space pregnancies in the interest of the mother and child's health and (3) keep women in the workforce.

Why Does Birth Control Matter to Women?

Birth control improves women's health by (1) preventing unintended and high-risk pregnancies, (2) enabling preventive behaviors and (3) allowing for the early detection of disease by getting women into doctor's offices for regular health screenings.

Women of reproductive age are in a particularly vulnerable position because they are more likely than other population groups to lack health insurance – in 2003, 20.5% of women ages 15-44 were uninsured. Unfortunately, the proportion of reproductive age women covered by Medicaid has been dwindling for several years.³ Efforts on the state and federal level to cut or cap Medicaid will further reduce this number and undermine this important source of health care for many low-income women.

Medicaid Covers Essential Birth Control and Saves Money

Medicaid provides vital contraceptive coverage to the millions of low-income women of reproductive age that depend on the program for their health care. Currently, 11.5% of U.S. women of reproductive age (15-44) are covered by Medicaid.⁴ Even those women who are not insured by the Medicaid program can have access to family planning services only through state family planning Medicaid expansions. (See below.)

Medicaid law, within certain guidelines, leaves it to each state to decide what services to include under

¹ Guttmacher Institute. "Medicaid Turns 40. What You Didn't Know About This Vital Source of Family Planning Funding." July 29, 2005. <http://www.guttmacher.org/media/inthenews/2005/07/29/index.html>

² The Medicaid statute does not define "family planning" nor does it provide any specific guidelines or regulations to help states determine which family planning services must be provided under their programs. But most states have come to include in their family planning definitions the full range of services that qualify as reproductive health care for women and men. Primary among these services is the direct provision of contraceptive methods.

³ The Alan Guttmacher Institute, "New Medicaid Initiative, State Budget Woes Collide," *Issues in Brief* 2002(5).

⁴ Adam Sonfield and Rachel Benson Gold, "Conservatives' Agenda Threaten Public Funding for Family Planning," *The Guttmacher Report* February 2005.

“family planning.” These services can include a range of reproductive health care.⁵ Most states generally cover major prescription birth control, gynecological exams, sterilization, and testing for and treatment of sexually transmitted diseases. In addition, 32 states and the District of Columbia also cover over-the-counter contraceptive methods such as condoms.⁶

Medicaid Is the Main Source of Funding for Birth Control and Needs to Be Preserved

The Guttmacher Institute estimates that in 2002 about 17 million women were in need of publicly funded contraceptive coverage.⁷ While other sources of family planning services for these women, such as Title X, have stagnated since the 1980s, Medicaid has grown. *Today, the Medicaid program accounts for two-thirds of all federal and state family planning funding nationwide.*⁸

Federal efforts are underway to weaken contraceptive coverage under Medicaid. In particular, this year’s Deficit Reduction Act threatens all mandatory services in Medicaid, including preventive services like birth control.

Many States Have Expanded Family Planning in Medicaid

There is a significant financial benefit to providing contraceptive coverage – every \$1 spent on family planning saves \$3 in Medicaid costs that otherwise would have gone for prenatal and newborn care. Currently, the Medicaid program finances almost 40% of all births in the U.S.⁹ Since the early 1990s, **25 states** have been granted special permission (known as “waivers” of federal policy) to expand Medicaid’s family planning coverage to low-income women who would not otherwise qualify for Medicaid’s full insurance program.¹⁰ An evaluation of these expansions by the Centers for Medicare and Medicaid Services found that the programs studied not only met the federal requirement that they not result in additional federal outlays, but in fact have *saved money for both the states and the federal government.*¹¹ As the federal and state governments consider changes to Medicaid in the name of saving money, important preventive services like birth control must be maintained, or even expanded as these states have done.

⁵ Abortion is not considered part of family planning. Furthermore, coverage of abortion under Medicaid is very limited. Under federal law (known as the Hyde amendment) Medicaid dollars can only be used to cover abortions in cases of rape or incest or if the woman’s life is endangered. Seventeen states use their own funds to go beyond the federal law and cover most medically necessary abortions. http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf

⁶ Renee Schwalberg et al., *Medicaid Coverage of Family Planning Services: Results of a National Survey*. The Henry J. Kaiser Family Foundation, Washington, DC: 2001.

⁷ Adam Sonfield and Rachel Benson Gold, “Conservatives’ Agenda Threaten Public Funding for Family Planning.” *The Guttmacher Report* February 2005.

⁸ Using AGI State-level data available at <http://www.guttmacher.org/pubs/2005/03/01/memo030105.pdf>

⁹ Emily V. Cornell, “MCH Update 2002: States’ Health Coverage for Low-Income Pregnant Women, Children, and parents,” *National Governors’ Association Issue Brief* (June 9, 2003).

¹⁰ In seven states—CA, MN, NC, NY, OK, OR, WA—men are also eligible to receive these services. The Alan Guttmacher Institute, “Medicaid Family Planning Waivers,” *State Policies in Brief* (January 19, 2006).

¹¹ Rachel Benson Gold, “Doing More for Less: Study Says State Medicaid Family Planning Expansions are Cost-Effective,” *The Guttmacher Report* March 2004, 1.

Medicaid Family Planning Services at a Crossroads

The Deficit Reduction Act of 2005 (DRA) allows states to avoid federal requirements governing which services certain groups of beneficiaries receive through Medicaid. This could have some especially troubling effects for women's health, and in particular, family planning coverage. However, many states are offering these services to an expanded population, which both allows women and men to control their reproductive lives and saves the state and federal governments money.

Before the DRA: Family Planning Required for Everyone

Before the DRA, it was clear that there were certain federal Medicaid requirements, known as **mandatory services**, that had to be provided, when medically necessary, to all Medicaid beneficiaries. Included among these services was family planning.

Medicaid law, within certain guidelines, leaves it to each state to decide what services to include under "family planning." *These services can include a range of reproductive health care other than abortion.*¹ Most states generally cover major prescription birth control, gynecological exams, sterilization, and testing for and treatment of sexually transmitted diseases. In addition, 32 states and the District of Columbia also cover over-the-counter contraceptive methods such as condoms.²

After the DRA: Reduced Benefit Packages for Parents and Children

Under the DRA, states can replace their traditional Medicaid plans with so-called "benchmark" plans. However, states can only require certain groups - *parents*³ *and children*⁴ - to use a benchmark plan instead of a traditional Medicaid plan.

Unfortunately, CMS, the agency responsible for overseeing Medicaid, has interpreted the DRA to allow states to enroll *all Medicaid beneficiaries* in benchmark plans, so long as certain groups may then "opt out" of the benchmark plan and go back to traditional Medicaid coverage. Of course, *"opting out" requires that beneficiaries know that they may return to a traditional Medicaid plan and understand how to do so.*

¹ Abortion is not considered part of family planning. Furthermore, coverage of abortion under Medicaid is very limited. Federal law - known as the Hyde amendment - requires that Medicaid dollars be used to cover abortions in cases of rape or incest or if the woman's life is endangered. Given the requirements of current law, this coverage should not be affected by the DRA. States have, and can continue, to go beyond federal law and cover all medically necessary abortions. As of April 2006, seventeen states use their own funds to do so.

² Renee Schwalberg et al., *Medicaid Coverage of Family Planning Services: Results of a National Survey*. The Henry J. Kaiser Family Foundation, Washington, DC: 2001.

³ Because of confusing guidance issued by CMS about the DRA, it is uncertain whether any parents will be exempted.

⁴ In an effort to preserve EPSDT, the DRA requires that children in benchmark plans also have a "wrap-around" plan to cover additional services when the benchmark plan doesn't cover all of the EPSDT services. Unfortunately, this is likely to create an administrative hurdle that will make it harder for children to get the comprehensive care to which they are entitled.

Benchmark plans are only required to offer benefits equivalent to those offered in either (1) the Federal Employee Health Benefits Program⁵, (2) the state's own state employee health benefits plan⁶, (3) the HMO with the largest non-Medicaid enrollment in the state,⁷ (4) the actuarial equivalent of one of these plans,⁸ or (5) whatever package the state designs that would be "appropriate for the population" so long as it is approved by the Secretary of Health and Human Services.

Under SCHIP: Family Planning Was Lost for Some

States were given the same options to design their benefit packages for SCHIP as they now have for their Medicaid plans. As a result, family planning is not covered in SCHIP in several states. In designing the SCHIP plan, *four states* - Montana, North Dakota, Pennsylvania and Texas - *chose packages that do not include coverage of contraceptives*. Additionally, family planning could be in danger in Alaska because it does not cover family planning in its state employee health plan. Ultimately, family planning is at risk in *any* state because of the authority given the Secretary to approve any package design.

Medicaid Family Planning Waivers: An Important Source of Coverage

Since the 1980's, states have been seeking waivers from the federal government to allow coverage of family planning services only for women (and sometimes men) who's income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. The states' incentive to offer this coverage is that the state will save money because there will be fewer births for the state to cover. Currently the income eligibility level for almost every state's family planning waiver mirrors their eligibility level for pregnancy services. Coverage ranges from 133% of FPL in Arizona and Alabama to 250% of FPL in Rhode Island and Maryland.⁹ The population served by waivers varies by state. Some states cover all women and men who meet the income eligibility level. Other states only cover women post-partum for a specified number of years.

Twenty-five states currently have family planning waivers and five more are pending with HHS. In order to get a waiver, the state must satisfy the HHS requirement that the state will spend no more dollars than what would be spent without the waiver. A recent HHS study looked at six states and concluded that every state actually saved federal and state dollars with their family planning waiver.¹⁰

Next Steps

Through the benchmark option, the DRA gives states unprecedented flexibility to cut any benefit, including family planning. These services are vital to women's health and therefore should continue to be a part of all Medicaid benefit packages. In addition, states can ensure that even more women and men gain access to these services by expanding coverage through a family planning waiver.

⁵ The standard Blue Cross/Blue Shield preferred provider plan that the federal government offers its employees.

⁶ Any health benefit plan that a state provides its employees.

⁷ States can also determine the value of the benefits offered in these plans and offer a plan with the same value (known as an actuarial equivalent plan).

⁸ This is referred to in the DRA as "benchmark equivalent coverage."

⁹ "State Medicaid Family Planning Eligibility Expansions" *State Policies in Brief*, The Guttmacher Institute, April 1, 2006.

¹⁰ "Medicaid: A Critical Source of Support for Family Planning in the United States." The Guttmacher Institute and The Henry J. Kaiser Family Foundation, April 2004, pg 9.

State Medicaid Family Planning Waiver-A Model from Minnesota

Minnesota has a Medicaid Section 1115 waiver to provide family planning services for low-income adults who would not otherwise qualify for Medicaid. The following waiver project can serve as a model for developing a family planning waiver in your state.

MINNESOTA FAMILY PLANNING DEMONSTRATION FACT SHEET

State: Minnesota

Name of Proposed Program: *Minnesota Family Planning Project*

Date Proposal Submitted: July 3, 2002

Date Proposal Approved: July 20, 2004

Date of Implementation: July 1, 2006

Expiration Date: June 30, 2011

ELIGIBILITY:

The Minnesota Family Planning Demonstration extends Medicaid eligibility for family planning services to women and men, between 15 and 50, with family income at or below 200 percent Federal poverty level (FPL), who are not otherwise eligible for Medicaid, SCHIP, Medicare, or any other creditable health insurance coverage.

FAMILY PLANNING SERVICES:

Family planning services include a contraceptive counseling, contraceptive supplies, devices, implants and prescriptions, office visits, laboratory examinations and tests, voluntary sterilization, HIV/STI testing in conjunction with a family planning encounter, and referrals to other health care providers for primary care.

COST SHARING:

There is no cost sharing (premiums or copayments) for enrollees covered under the family planning demonstration.

PRIMARY CARE REFERRAL SYSTEM:

All enrollees of the Family Planning Program will also receive information about Minnesota's other health care programs, which cover primary care services. Enrollees who apply for the Family Planning Program via a medical provider will receive a Minnesota Health Care Programs Brochure upon application. This brochure contains a description of each Minnesota public health program, a list of covered services, basic eligibility criteria and contact phone numbers.

Training on this program will be made available to providers, and they will be kept informed of program changes over time through the Provider Updates that the Minnesota Department of Human Services.

EVALUATION:

Project objectives:

- Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs.

- Increase the number of men and women enrolled in Minnesota Health Care Programs who utilize family planning services.
- Reduce the number of unintended pregnancies among women and teens enrolled in Minnesota Health Care Programs.
- Reduce the proportion of pregnancies of Minnesota Health Care Programs enrollees that are spaced less than two years apart.
- Expand provision of family planning services to adolescents and other Minnesotans who do not traditionally access public health programs.

ESTIMATED ENROLLMENT AND COST OF DEMONSTRATION:

- The Minnesota Family Planning Project will serve approximately 30,000 enrollees when fully operational.
- Savings of \$2,179,563 (Federal share) are projected for the 5-year demonstration period.

Date Last Updated: June 27, 2006

To view and download Minnesota's entire waiver proposal, please visit the CMS website:
<http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=dual,%20data&filterValue=Minnesota&filterByDID=2&sortByDID=2&sortOrder=ascending&itemID=CMS060773&intNumPerPage=10>

Medicaid Family Planning Waivers: Providing Parity for Reproductive Health Services and Achieving Fiscal Savings for States

Recent studies suggest a growing and disturbing disparity between poor and affluent women that has a substantial impact on their health and lives. Between 1994 and 2001, the rate of unintended pregnancies for affluent women fell by 20%, while the rate of unintended pregnancies for women living below poverty rose by 29%. A poor woman in the United States is now nearly four times as likely as a more affluent woman to have an unplanned pregnancy.¹

Expanding access to family planning services through Medicaid is a cost-effective way to reduce the number of unintended pregnancies and improve the health and lives of low-income women. Over the past decade, states have been experimenting with Medicaid family planning expansions by seeking what are known as “family planning waivers” to achieve these goals.

What are Family Planning Waivers?

Since the early 1990s, 25² states have been granted special permission (known as a “waiver” of federal law) from the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicaid program, to expand Medicaid’s family planning coverage to low-income women who would not otherwise qualify for Medicaid’s full insurance program.³

There are two types of family planning waivers: the first, an income-based waiver, expands eligibility for family planning services to all women of reproductive age⁴ (and sometimes men) up to a certain income level. Most of these income-based waivers expand eligibility for family planning services to the same income-level at which women are eligible for pregnancy-related services, should they choose to become pregnant. This type of income-based waiver is sometimes known as a “parity waiver,” because it creates parity between the income level at which women are eligible for family planning services and the income level at which women are eligible for pregnancy-related care.

Some states have opted for a second type of family planning waiver, a more limited family planning waiver that extends family planning services only to certain women who have been Medicaid enrollees due to their status as pregnant women or parents. Typically these waivers extend coverage for one or two years.⁵

Income-based parity waivers are preferable because they provide family planning services to significantly more women and have been shown to provide significant cost savings to states.

¹ Gold RB. “Rekindling Efforts to Prevent Unplanned Pregnancy: A Matter of ‘Equity and Common Sense.’” *Guttmacher Policy Review*, Volume 9, Number 3, Summer 2006.

² In addition to the 25 approved waivers, a waiver application from Massachusetts is currently pending.

³ In seven states—CA, MN, NC, NY, OK, OR, WA—men are also eligible to receive these services. See The Alan Guttmacher Institute, “Medicaid Family Planning Waivers,” *State Policies in Brief*, December 2006.

⁴ In eight states—AL, IL, LA, MI, NM, NC, OK, TX—services are available for individuals aged 19 years and older.

⁵ An additional 8 states have more limited family planning waivers that extend coverage only to certain women who have been Medicaid enrollees due to their status as pregnant women or parents: AZ, DE, FL, IL, MD, MO, RI, VA.

What are the Goals of Family Planning Waivers?

Minnesota⁶ cited the following objectives and purposes for its income-based family planning waiver in its proposal:

- Increase the number of individuals who have access to family planning services through the state's Medicaid program;
- Increase the number of individuals enrolled in the state's Medicaid program who utilize family planning services;
- Reduce the number of unintended pregnancies among women enrolled in the state's Medicaid program;
- Reduce the number of unintended pregnancies among teens enrolled in the state's Medicaid program;
- Reduce the proportion of Medicaid pregnancies that are spaced less than two years apart; and
- Expand provision of family planning services to individuals who do not traditionally access public health programs.

Why are Family Planning Waivers Important?

Medicaid family planning waivers help meet the need for subsidized family planning services. A recent study found that publicly-funded clinics in the seven states with income-based waivers in 2001 were able to meet more of the need for subsidized contraceptive services than clinics in other states.⁷

Evidence suggests that Medicaid family planning waivers reduce the number of unintended pregnancies. Based on a review of the FamilyPACT program in California, researchers estimate that FamilyPACT prevented 213,000 unintended pregnancies, 45,000 which would have been to teenagers, in 2002.⁸

Medicaid family planning waivers save states money. Each dollar spent to provide publicly-funded family planning services saves the Medicaid program more than \$3 in pregnancy-related care alone.⁹

What are the Cost Benefits of Family Planning Waivers?

An evaluation of income-based family planning waivers commissioned by the Centers for Medicare and Medicaid Services (CMS) found that the programs studied not only met the federal requirement that they achieve budget neutrality, but in fact have saved money for both the states and the federal government.¹⁰

⁶ To view Minnesota's waiver application in its entirety, see

<http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp?filtertype=dual&datefiltertype=1&datefilterinterval=&filtertype=data&datafiltertype=2&datafiltervalue=Minnesota&filtertype=keyword&keyword=family+planning&intNumPerPage=10&cmdFilterList=Show+Items>

⁷ Frost, J, Frohwirth, L. and Purcell, A. "The Availability and Use of Publicly Funded Family Planning Clinics: U.S. Trends, 1994-2001," *Perspectives in Sexual and Reproductive Health*, Sept./October 2004.

⁸ The Henry J Kaiser Family Foundation and The Alan Guttmacher Institute, "Medicaid: A Critical Source of Support for Family Planning in the United States," Issue Brief (April 2005).

⁹ Ibid.

¹⁰ Gold, RB. "Doing More for Less: Study Says State Medicaid Family Planning Expansions are Cost-Effective," *The Guttmacher Report*, March 2004.

State-by-State Analysis of Cost Savings Associated with Medicaid Family Planning Waivers¹¹

State	Year	Decrease in # of Births	Total Savings	State Savings	Federal Savings
Alabama	2000-2001	3,162	\$19,028,783	\$6,981,721	\$12,047,062
Arkansas	1997-1998	2,748	\$15,524,056	\$5,199,426	\$10,324,630
	1998-1999	4,486	\$29,748,208	\$9,411,954	\$20,336,254
California	1999-2000	21,335	\$76,182,694	\$64,314,302	\$11,868,392
New Mexico	1998-1999	507	\$1,334,435	\$652,918	\$681,517
	1999-2000	1,358	\$5,009,165	\$2,037,590	\$2,971,575
	2000-2001	1,528	\$6,510,909	\$2,650,439	\$3,860,470
Oregon	2000	5,414	\$19,756,294	\$11,077,646	\$8,678,648
South Carolina	1994-1995	2,228	\$13,634,174	\$4,135,453	\$9,498,721
	1995-1996	3,151	\$19,615,968	\$6,201,946	\$13,414,022
	1996-1997	3,769	\$23,066,926	\$7,403,462	\$15,633,464

Which States Currently Have Income-Based Family Planning Waivers?

Seventeen states have income-based family planning waivers. Eligibility levels vary from 133% of the Federal Poverty Level (FPL) to 200% FPL.

Income Eligibility Levels for Family Planning Services under Medicaid Waivers

State	Income Level (as % of FPL)	Monthly Income Level
Alabama	133	\$1,839
Arkansas	200	\$2,766
California	200	\$2,766
Iowa	200	\$2,766
Louisiana	200	\$2,766
Michigan	185	\$2,559
Minnesota ¹²	200	\$2,766
Mississippi	185	\$2,559
New Mexico	185	\$2,559
New York	200	\$2,766
North Carolina	185	\$2,559
Oklahoma	185	\$2,559
Oregon	185	\$2,559
South Carolina	185	\$2,559
Texas	185	\$2,559
Washington	200	\$2,766
Wisconsin	185	\$2,559

¹¹ Edwards, J., Bronstein, J. and Adams, K., "Evaluation of Medicaid Family Planning Demonstrations," The CNA Corporation, CMS Contract No. 752-2-415921, November 2003. State calculations estimated by The Alan Guttmacher Institute based on the total savings and the CNA Corporation's analysis of the federal share of savings in the final report.

¹² Minnesota proposed eligibility coverage for men and women up to 250% FPL in its waiver application but CMS approved coverage up to 200% FPL only.

Conclusion

At a time when states are struggling to reduce the number of unintended pregnancies and find ways to reduce Medicaid expenses, income-based family planning waivers are not only good health policy, but good fiscal policy, as well.

Health Care for the Poor: Who Is Eligible for Medicaid in Arizona

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.¹ Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

Income Eligible Groups under Medicaid:

- (1) **Children** – An infant less than one year old becomes eligible by residing in a family of 3 with an income at or below \$1,936/month. A child up to age 6 becomes eligible with an income at or below \$1,839/month. A child between 6 and 19 qualifies if their family income is \$1,383/month.
- (2) **Parents** – A parent becomes eligible for Medicaid if he or she resides in a family of three with an income of roughly \$2,767/month.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$1,839/month for her family of 3. Coverage extends throughout the pregnancy and for 60 days postpartum. Arizona could opt to cover women whose income is up to \$2,559/month and still receive a federal match.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$605/month, the income standard used to determine eligibility for Supplemental Security Income (SSI).²
- (5) **Elderly Populations** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their incomes are low enough. Seniors can get coverage for the full Medicaid benefits package plus assistance with Medicare premiums and cost-sharing or just the latter. Because these standards mirror those of the SSI program, an elderly individual also qualifies for Medicaid if his/her income is at or below \$605/month.

Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.³ Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women under age 65 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC)

¹ There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets.

² There is one notable exception to this minimum income level. Some states exercise what is known as a 209(b) option which allows states to use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972.

³ To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

and do not have other health care coverage may qualify for the basic Medicaid benefits package if their individual income is up to roughly \$2,042/month.⁴

- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. In Arizona, a woman who received Medicaid during her pregnancy and would have lost coverage 60 days postpartum is eligible to receive family planning services for up to two years. (This waiver expired on September 30, 2006).⁵

⁴ Georgetown University Health Policy Institute "A Consumer's Guide to Getting and Keeping Health Insurance Arizona," December 2004, <http://www.healthinsuranceinfo.net/az05.html>

⁵ The Alan Guttmacher Institute, "Medicaid Family Planning Waivers," *State Policies in Brief* (November 1, 2006).

Cuts to Medicaid Will Hurt Arizona's Women

Federal and State Reforms to Medicaid Amount to Drastic Cuts

Medicaid is a vital source of insurance for millions of low-income Americans. The program currently provides health insurance coverage to nearly 55 million parents, children, pregnant women, elderly and people with disabilities. For those individuals that qualify, who are the poorest among us, Medicaid provides coverage for a panoply of important health care services, including physician and hospital care, preventive screenings, pregnancy-related care, contraceptive coverage and long-term care services. Medicaid provides these services in an efficient manner; in the wake of a health insurance market that has seen dramatically rising costs, Medicaid's costs have grown at *half the rate* of private insurers.¹

Yet, policy makers on both the federal and state levels have called for "reforms" to the Medicaid program. President Bush has consistently supported limiting funding for the Medicaid program and has even proposed capping federal funding to the states. Congress has followed with major legislative changes that allow states to limit benefit packages and charge beneficiaries more for their care. Some states have applied to the federal government for very broad waivers in order to get out of certain federal requirements that guarantee benefits and restrict cost-sharing. The loss of these federal protections leaves many beneficiaries vulnerable to severe benefit reductions, high out of pocket costs and even removal from the program.

Why Do These Cuts Matter to Arizona Women?

Medicaid in Arizona provides vital health care services to low-income women, who comprise **79% of beneficiaries age 19 and older**.² Women are *twice* as likely as men to qualify for Medicaid because they are poorer and more likely to meet the stringent eligibility criteria and because they are in lower paying jobs that are less likely to come with employer-sponsored insurance. Health insurance is critical to women because mothers with health insurance are more likely to stay employed and get health care for their children than those lacking insurance.

Arizona Women Rely on Medicaid for a Range of Services

- *Very low-income parents* with dependent children and incomes up to 200% of the federal poverty level (FPL), or roughly \$2,767 a month for a family of three, can get comprehensive services.³ These services help keep these women healthy, which allows them to take care of their families and remain in the workforce.
- *Low-income pregnant women*, with incomes up to 133% of FPL or roughly \$1,086 a month for an individual, can get prenatal care. In Arizona, **45.4% of all births in the state are paid for by Medicaid**.

¹ John Holahan and Arunabh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

² Kaiser Commission on Medicaid and the Uninsured analysis of 2001 MSIS data.

³ Unless otherwise noted, all state facts are from Kaiser Family Foundation State Health Facts online, available at <http://www.statehealthfacts.org>. All references to the federal poverty level are for 2006. <http://aspe.hhs.gov/poverty/05poverty.shtml>.

- *Low-income disabled and aged people* are eligible for Medicaid if their incomes are at or below 74% of FPL, or roughly \$605 a month for an individual. These beneficiaries rely on Medicaid for both comprehensive care and long-term services, the latter of which are extremely costly and can have a devastating financial impact on women with fixed incomes. Medicaid is the largest source of funding for people in nursing homes, who tend to be women over 80 without a spouse or close relative living in their community.
- *Low-income women who have breast and cervical cancer* and who are diagnosed through the CDC screening program can receive treatment for their illness if they are under 65 and their income is at or below 250% of FPL, or roughly \$2,042 a month for an individual.⁴
- *Low-income women in need of family planning* who received Medicaid during their pregnancy and would have lost Medicaid coverage after 60 days postpartum can receive family planning services for up to two years. They can get coverage for contraception, sterilization, gynecological care, and STD testing and treatment.⁵

Arizona Depends on the Federal Government for 67% of Program Costs

In Arizona, the Medicaid program is run jointly by the federal, state and county governments. The federal government contributes a share of the program's costs, based on the per capita income in the state. The federal share of costs in Arizona is 67%. **Total Medicaid costs for the program in 2005 will be nearly \$6 billion, \$4.1 billion of which will come from the federal government.**⁶

Medicaid Is Cost Effective

Medicaid is more efficient than traditional private health insurance programs. **Medicaid spends 30% less per adult than private coverage.**⁷ **Also, Medicaid costs have been growing at slightly more than half the rate of the cost of private insurance,**⁸ despite the fact that Medicaid faces increased enrollment during weak economic times.

Budget Cuts Will Hurt Arizona's Medicaid Program

The cuts to Medicaid in the federal budget will result in a loss of health coverage for women and their families in Arizona. States will be receiving less federal funding for their programs and will be forced to cut eligibility and/or eliminate or cap services in order to recover from this loss. Even without the loss created by this significant reduction in federal funds, many states have been considering Medicaid cuts of their own. For women in these states, the loss of federal funds will be even more devastating.

⁴ <http://www.healthinsuranceinfo.net/az05.html>.

⁵ This does not include HIV/AIDS treatment.

⁶ Families USA, "Medicaid Cuts are Bad Medicine: Arizona," January 2005, available at http://www.familiesusa.org/site/DocServer/Medicaid_cuts_Arizona.pdf?docID=5622.

⁷ Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, Winter 2003/2004.

⁸ John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003, available at <http://www.kff.org/insurance/ehbs2003-abstract.cfm>.

Health Care for the Poor: Who Is Eligible for Medicaid in Colorado

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.¹ Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

Income Eligible Groups under Medicaid:

- (1) **Children** – An infant less than one year old becomes eligible by residing in a family of 3 with an income at or below \$1,839/month. A child up to age 6 becomes eligible with an income at or below \$1,839/month. A child between 6 and 19 qualifies if their family income is \$1,383/month.
- (2) **Parents** – A parent becomes eligible for Medicaid if he or she resides in a family of three with an income of roughly \$920/month.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,767/month for her family of 3. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$605/month, the income standard used to determine eligibility for Supplemental Security Income (SSI).²
- (5) **Elderly Populations** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their incomes are low enough. Seniors can get coverage for the full Medicaid benefits package plus assistance with Medicare premiums and cost-sharing or just the latter. Because these standards mirror those of the SSI program, an elderly individual also qualifies for Medicaid if his/her income is at or below \$605/month.

Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.³ Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women between the ages of 40 and 64 with breast or cervical cancer who have been screened by the Centers for Disease Control and

¹ There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets.

² There is one notable exception to this minimum income level. Some states exercise what is known as a 209(b) option which allows states to use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972.

³ To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

Prevention (CDC) and do not have other health care coverage may qualify for the basic Medicaid benefits package if their individual income is up to roughly \$2,042/month.⁴

- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. Colorado does not have a family planning waiver.⁵

⁴ Georgetown University Health Policy Institute "A Consumer's Guide to Getting and Keeping Health Insurance in Colorado," January 2006, p. 29 <http://www.healthinsuranceinfo.net/co00.html>

⁵ The Alan Guttmacher Institute, "Medicaid Family Planning Waivers," *State Policies in Brief* (November 1, 2006). National Women's Law Center, Washington, DC, December 2006

Cuts to Medicaid Will Hurt Colorado's Women

Federal and State Reforms to Medicaid Amount to Drastic Cuts

Medicaid is a vital source of insurance for millions of low-income Americans. The program currently provides health insurance coverage to nearly 55 million parents, children, pregnant women, elderly and people with disabilities. For those individuals that qualify, who are the poorest among us, Medicaid provides coverage for a panoply of important health care services, including physician and hospital care, preventive screenings, pregnancy-related care, contraceptive coverage and long-term care services. Medicaid provides these services in an efficient manner; in the wake of a health insurance market that has seen dramatically rising costs, Medicaid's costs have grown at *half the rate* of private insurers.¹

Yet, policy makers on both the federal and state levels have called for "reforms" to the Medicaid program. President Bush has consistently supported limiting funding for the Medicaid program and has even proposed capping federal funding to the states. Congress has followed with major legislative changes that allow states to limit benefit packages and charge beneficiaries more for their care. Some states have applied to the federal government for very broad waivers in order to get out of certain federal requirements that guarantee benefits and restrict cost-sharing. The loss of these federal protections leaves many beneficiaries vulnerable to severe benefit reductions, high out of pocket costs and even removal from the program.

Why Do These Cuts Matter to Colorado Women?

Medicaid in Colorado provides vital health care services to low-income women, who comprise **73% of beneficiaries age 19 and older**.² Women are *twice* as likely as men to qualify for Medicaid because they are poorer and more likely to meet the stringent eligibility criteria and because they are in lower paying jobs that are less likely to come with employer-sponsored insurance. Health insurance is critical to women because mothers with health insurance are more likely to stay employed and get health care for their children than those lacking insurance.

Colorado Women Rely on Medicaid for a Range of Services

- *Very low-income parents* with dependent children and incomes up to 67% of the federal poverty level (FPL), or roughly \$920 a month for a family of three, can get comprehensive services.³ These services help keep these women healthy, which allows them to take care of their families and remain in the workforce.
- *Low-income pregnant women*, with incomes up to 200% of FPL or roughly \$1,634 a month for an individual, can get prenatal care. In Colorado, **31.6% of births in the state are paid for by Medicaid**.

¹ John Holahan and Arunabh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

² Kaiser Commission on Medicaid and the Uninsured analysis of 2001 MSIS data.

³ Unless otherwise noted, all state facts are from Kaiser Family Foundation State Health Facts online, available at <http://www.statehealthfacts.org>. All references to the federal poverty level are for 2006. <http://aspe.hhs.gov/poverty/05poverty.shtml>.

- *Low-income disabled and aged people* are eligible for Medicaid if their incomes are at or below 74% of FPL, or roughly \$605 a month for an individual. These beneficiaries rely on Medicaid for both comprehensive care and long-term services, the latter of which are extremely costly and can have a devastating financial impact on women with fixed incomes. Medicaid is the largest source of funding for people in nursing homes, who tend to be women over 80 without a spouse or close relative living in their community.
- *Low-income women who have breast and cervical cancer* and who are diagnosed through the CDC screening program can receive treatment for their illness if their income is at or below 250% of FPL, or roughly \$2,042 a month for an individual, and if they are between the ages of 40 and 64.⁴
- *Low-income women in need of family planning* can receive these vital reproductive health services if they qualify for Medicaid. In Colorado, family planning, which is a mandatory service, includes physical exams and contraceptive counseling and follow up.⁵

Colorado Depends on the Federal Government for 50% of Program Costs

In Colorado, the Medicaid program is run jointly by the federal, state and county governments. The federal government contributes a share of the program's costs, based on the per capita income in the state. The federal share of costs in Colorado is 50%. **Total Medicaid costs for the program in 2005 will be nearly \$2.9 billion, \$1.4 billion of which will come from the federal government.**⁶

Medicaid Is Cost Effective

Medicaid is more efficient than traditional private health insurance programs. **Medicaid spends 30% less per adult than private coverage.**⁷ Also, **Medicaid costs have been growing at slightly more than half the rate of the cost of private insurance,**⁸ despite the fact that Medicaid faces increased enrollment during weak economic times.

Budget Cuts Will Hurt Colorado's Medicaid Program

The cuts to Medicaid in the federal budget will result in a loss of health coverage for women and their families in Colorado. States will be receiving less federal funding for their programs and will be forced to cut eligibility and/or eliminate or cap services in order to recover from this loss. Even without the loss created by this significant reduction in federal funds, many states have been considering Medicaid cuts of their own. For women in these states, the loss of federal funds will be even more devastating.

⁴ <http://www.healthinsuranceinfo.net/co05.html>

⁵ Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services: Results of a National Survey* (Menlo Park: The Henry J. Kaiser Family Foundation, November 2001), 60, available at <http://www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13737>.

⁶ Families USA, "Medicaid Cuts are Bad Medicine: Colorado," January 2005, available at http://www.familiesusa.org/site/DocServer/Medicaid_cuts_Colorado.pdf?docID=5624.

⁷ Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, Winter 2003/2004.

⁸ John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-20003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003, available at <http://www.kff.org/insurance/ehbs2003-abstract.cfm>.

Health Care for the Poor: Who Is Eligible for Medicaid in Florida

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.¹ Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

Income Eligible Groups under Medicaid:

- (1) **Children** – An infant less than one year old becomes eligible by residing in a family of 3 with an income at or below \$2,766/month. A child up to age 6 becomes eligible with an income at or below \$1,839/month. A child between 6 and 19 qualifies if their family income is \$1,383/month.
- (2) **Parents** – A non-working parent becomes eligible for Medicaid if he or she resides in a family of 3 with an income of roughly \$318/month. A working parent in a family of 3 is eligible with an income of roughly \$806/month.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,559/month for her family of 3. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below roughly \$605/month, the income standard used to determine eligibility for Supplemental Security Income (SSI).²
- (5) **Elderly Populations** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their incomes are low enough. Seniors can get coverage for the full Medicaid benefits package plus assistance with Medicare premiums and cost-sharing or just the latter. An elderly individual qualifies for Medicaid if his/her income is at or below \$735/month.

Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.³ Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women under age 65 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC)

¹ There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets.

² There is one notable exception to this minimum income level. Some states exercise what is known as a 209(b) option which allows states to use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972.

³ To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

and do not have other health care coverage may qualify for the basic Medicaid benefits package if their individual income is up to roughly \$1,634/month.⁴

- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. In Florida, a woman who received Medicaid during her pregnancy and would have lost coverage 60 days postpartum is eligible to receive family planning services for up to two years. (This waiver expired on November 30, 2006).⁵

⁴ Georgetown University Health Policy Institute "A Consumer's Guide to Getting and Keeping Health Insurance in Florida," December 2004, <http://www.healthinsuranceinfo.net/fl00.html>

⁵ The Alan Guttmacher Institute, "Medicaid Family Planning Waivers," *State Policies in Brief* (November 1, 2006).

Cuts to Medicaid Will Hurt Florida's Women

Federal and State Reforms to Medicaid Amount to Drastic Cuts

Medicaid is a vital source of insurance for millions of low-income Americans. The program currently provides health insurance coverage to nearly 55 million parents, children, pregnant women, elderly and people with disabilities. For those individuals that qualify, who are the poorest among us, Medicaid provides coverage for a panoply of important health care services, including physician and hospital care, preventive screenings, pregnancy-related care, contraceptive coverage and long-term care services. Medicaid provides these services in an efficient manner; in the wake of a health insurance market that has seen dramatically rising costs, Medicaid's costs have grown at *half the rate* of private insurers.¹

Yet, policy makers on both the federal and state levels have called for "reforms" to the Medicaid program. President Bush has consistently supported limiting funding for the Medicaid program and has even proposed capping federal funding to the states. Congress has followed with major legislative changes that allow states to limit benefit packages and charge beneficiaries more for their care. Some states have applied to the federal government for very broad waivers in order to get out of certain federal requirements that guarantee benefits and restrict cost-sharing. The loss of these federal protections leaves many beneficiaries vulnerable to severe benefit reductions, high out of pocket costs and even removal from the program.

Why Do These Cuts Matter to Florida Women?

Medicaid in Florida provides vital health care services to low-income women, who comprise **72% of beneficiaries age 19 and older.**² Women are *twice* as likely as men to qualify for Medicaid because they are poorer and more likely to meet the stringent eligibility criteria and because they are in lower paying jobs that are less likely to come with employer-sponsored insurance. Health insurance is critical to women because mothers with health insurance are more likely to stay employed and get health care for their children than those lacking insurance.

Florida Women Rely on Medicaid for a Range of Services

- *Very low-income parents* with dependent children and incomes up to 58% of the federal poverty level (FPL), or roughly \$806 a month for a family of three, can get comprehensive services.³ These services help keep these women healthy, which allows them to take care of their families and remain in the workforce.
- *Low-income pregnant women*, with incomes up to 185% of FPL or roughly \$1,511 a month for an individual, can get prenatal care. In Florida, **46.2% of all births in the state are paid for by Medicaid.**

¹ John Holahan and Arunabh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

² Kaiser Commission on Medicaid and the Uninsured analysis of 2001 MSIS data.

³ Unless otherwise noted, all state facts are from Kaiser Family Foundation State Health Facts online, available at <http://www.statehealthfacts.org>. All references to the federal poverty level are for 2006. <http://aspe.hhs.gov/poverty/05poverty.shtml>.

- *Low-income disabled and aged people* are eligible for Medicaid if their incomes are at or below 90% of FPL, or roughly \$735 a month for an individual. These beneficiaries rely on Medicaid for both comprehensive care and long-term services, the latter of which are extremely costly and can have a devastating financial impact on women with fixed incomes. Medicaid is the largest source of funding for people in nursing homes, who tend to be women over 80 without a spouse or close relative living in their community.
- *Low-income women who have breast and cervical cancer* and who are diagnosed through the CDC screening program can receive treatment for their illness if they are under 65 and their income is at or below 200% of FPL, or roughly \$1,634 a month for an individual.⁴
- *Low-income women in need of family planning* who received Medicaid during their pregnancy and would have lost Medicaid coverage after 60 days postpartum can receive family planning services for up to two years.⁵

Florida Depends on the Federal Government for 59% of Program Costs

In Florida, the Medicaid program is run jointly by the federal, state and county governments. The federal government contributes a share of the program's costs, based on the per capita income in the state. The federal share of costs in Florida is 59%. **Total Medicaid costs for the program in 2005 will be nearly \$13.8 billion, \$8.1 billion of which will come from the federal government.**⁶

Medicaid Is Cost Effective

Medicaid is more efficient than traditional private health insurance programs. **Medicaid spends 30% less per adult than private coverage.**⁷ **Also, Medicaid costs have been growing at half the rate of the cost of private insurance,**⁸ despite the fact that Medicaid faces increased enrollment during weak economic times.

Budget Cuts Will Hurt Florida's Medicaid Program

The cuts to Medicaid in the federal budget will result in a loss of health coverage for women and their families in Florida. States will be receiving less federal funding for their programs and will be forced to cut eligibility and/or eliminate or cap services in order to recover from this loss. Even without the loss created by this significant reduction in federal funds, many states have been considering Medicaid cuts of their own. For women in these states, the loss of federal funds will be even more devastating.

⁴ <http://www.healthinsuranceinfo.net/fl05.html>

⁵ This does not include HIV/AIDS treatment.

⁶ Families USA, "Medicaid Cuts are Bad Medicine: Florida," January 2005, available at http://www.familiesusa.org/site/DocServer/Medicaid_cuts_Florida.pdf?docID=5625.

⁷ Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, Winter 2003/2004.

⁸ John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-20003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003, available at <http://www.kff.org/insurance/ehbs2003-abstract.cfm>.

Health Care for the Poor: Who Is Eligible for Medicaid in Maine

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.¹ Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

Income Eligible Groups under Medicaid:

- (1) **Children** – An infant less than one year old becomes eligible by residing in a family of 3 with an income at or below \$2,766/month. A child up to age 19 becomes eligible with a family income at or below \$2,075/month.
- (2) **Parents** – A non-working parent becomes eligible for Medicaid if he or she resides in a family of 3 with an income of roughly \$2,766/month. A working parent in a family of 3 is eligible with an income of roughly \$2,857/month.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,766/month for her family of 3. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below roughly \$605/month, the income standard used to determine eligibility for Supplemental Security Income (SSI).²
- (5) **Elderly Populations** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their incomes are low enough. Seniors can get coverage for the full Medicaid benefits package plus assistance with Medicare premiums and cost-sharing or just the latter. An elderly individual qualifies for Medicaid if his/her income is at or below roughly \$817/month.

Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.³ Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women under age 65 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC)

¹ There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets.

² There is one notable exception to this minimum income level. Some states exercise what is known as a 209(b) option which allows states to use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972.

³ To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

and do not have other health care coverage may qualify for the basic Medicaid benefits package if their individual income is up to roughly \$2,043/month.⁴

- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. Maine does not have a family planning waiver.⁵

⁴ Georgetown University Health Policy Institute "A Consumer's Guide to Getting and Keeping Health Insurance in Maine," January 2006, <http://www.healthinsuranceinfo.net/me00.html>

⁵ The Alan Guttmacher Institute, "Medicaid Family Planning Waivers," *State Policies in Brief* (November 1, 2006).

Cuts to Medicaid Will Hurt Maine's Women

Federal and State Reforms to Medicaid Amount to Drastic Cuts

Medicaid is a vital source of insurance for millions of low-income Americans. The program currently provides health insurance coverage to nearly 55 million parents, children, pregnant women, elderly and people with disabilities. For those individuals that qualify, who are the poorest among us, Medicaid provides coverage for a panoply of important health care services, including physician and hospital care, preventive screenings, pregnancy-related care, contraceptive coverage and long-term care services. Medicaid provides these services in an efficient manner; in the wake of a health insurance market that has seen dramatically rising costs, Medicaid's costs have grown at *half the rate* of private insurers.¹

Yet, policy makers on both the federal and state levels have called for "reforms" to the Medicaid program. President Bush has consistently supported limiting funding for the Medicaid program and has even proposed capping federal funding to the states. Congress has followed with major legislative changes that allow states to limit benefit packages and charge beneficiaries more for their care. Some states have applied to the federal government for very broad waivers in order to get out of certain federal requirements that guarantee benefits and restrict cost-sharing. The loss of these federal protections leaves many beneficiaries vulnerable to severe benefit reductions, high out of pocket costs and even removal from the program.

Why Do These Cuts Matter to Maine Women?

Medicaid in Maine provides vital health care services to low-income women, who comprise **56% of beneficiaries age 19 and older**.² Women are *twice* as likely as men to qualify for Medicaid because they are poorer and more likely to meet the stringent eligibility criteria and because they are in lower paying jobs that are less likely to come with employer-sponsored insurance. Health insurance is critical to women because mothers with health insurance are more likely to stay employed and get health care for their children than those lacking insurance.

Maine Women Rely on Medicaid for a Range of Services

- *Very low-income parents* with dependent children and incomes up to 207% of the federal poverty level (FPL), or roughly \$2,857 a month for a family of three, can get comprehensive services.³ These services help keep these women healthy, which allows them to take care of their families and remain in the workforce.
- *Low-income pregnant women* with incomes up to 200% of FPL, or roughly \$1,634 a month for an individual, can get prenatal care. In Maine, **33.4% of all births in the state are paid for by Medicaid**.

¹ John Holahan and Arunabh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

² Kaiser Commission on Medicaid and the Uninsured analysis of 2001 MSIS data.

³ Unless otherwise noted, all state facts are from Kaiser Family Foundation State Health Facts online, available at <http://www.statehealthfacts.org>. All references to the federal poverty level are for 2006. <http://aspe.hhs.gov/poverty/05poverty.shtml>.

- *Low-income disabled and aged people* are eligible for Medicaid if their incomes are at or below 100% of FPL, or roughly \$817 a month for an individual. These beneficiaries rely on Medicaid for both comprehensive care and long-term services, the latter of which are extremely costly and can have a devastating financial impact on women with fixed incomes. Medicaid is the largest source of funding for people in nursing homes, who tend to be women over 80 without a spouse or close relative living in their community.
- *Low-income women who have breast and cervical cancer* and who are diagnosed through the CDC screening program can receive treatment for their illness if they are under the age of 65 and their individual income is up to \$2,043/month.⁴
- *Low-income women in need of family planning* can receive these vital reproductive health services if they qualify for Medicaid. Family planning, which is currently a mandatory service, includes coverage for contraceptive supplies; consultation and information about contraception, infertility, and STDs; and referrals for STD testing and treatment.

Maine Depends on the Federal Government for 63% of Program Costs

In Maine, the Medicaid program is run jointly by the federal, state and county governments. The federal government contributes a share of the program's costs, based on the per capita income in the state. The federal share of costs in Maine is 63%. **Total Medicaid costs for the program in 2005 will be nearly \$2.2 billion, \$1.4 billion of which will come from the federal government.**⁵

Medicaid Is Cost Effective

Medicaid is more efficient than traditional private health insurance programs. **Medicaid spends 30% less per adult than private coverage.**⁶ **Also, Medicaid costs have been growing at slightly more than half the rate of the cost of private insurance,**⁷ despite the fact that Medicaid faces increased enrollment during weak economic times.

Budget Cuts Will Hurt Maine's Medicaid Program

The cuts to Medicaid in the federal budget will result in a loss of health coverage for women and their families in Maine. States will be receiving less federal funding for their programs and will be forced to cut eligibility and/or eliminate or cap services in order to recover from this loss. Even without the loss created by this significant reduction in federal funds, many states have been considering Medicaid cuts of their own. For women in these states, the loss of federal funds will be even more devastating.

⁴ <http://www.healthinsuranceinfo.net/me.pdf>

⁵ Families USA, "Medicaid Cuts are Bad Medicine: Maine," January 2005, available at http://www.familiesusa.org/site/DocServer/Medicaid_cuts_Maine.pdf?docID=5632.

⁶ Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, Winter 2003/2004

⁷ John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-20003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003, available at <http://www.kff.org/insurance/ehbs2003-abstract.cfm>.

Health Care for the Poor: Who Is Eligible for Medicaid in Missouri

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.¹ Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

Income Eligible Groups under Medicaid:

- (1) **Children** – A child up to age 19 becomes eligible by residing in a family of 3 with an income at or below \$4,149/month.
- (2) **Parents** – A non-working parent becomes eligible for Medicaid if he or she resides in a family of 3 with an income of roughly \$290/month. A working parent in a family of 3 is eligible with an income of roughly \$556/month.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,559/month for her family of 3. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below roughly \$605/month, the income standard used to determine eligibility for Supplemental Security Income (SSI).²
- (5) **Elderly Populations** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their incomes are low enough. Seniors can get coverage for the full Medicaid benefits package plus assistance with Medicare premiums and cost-sharing or just the latter. An elderly individual qualifies for Medicaid if his/her income is at or below roughly \$817/month.

Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.³ Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women between the ages of 35 and 65 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC) and do not have other health care coverage may receive treatment for their illness if their individual income is below \$1,634/month.⁴

¹ There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets.

² There is one notable exception to this minimum income level. Some states exercise what is known as a 209(b) option which allows states to use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972.

³ To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

⁴ Georgetown University Health Policy Institute “A Consumer’s Guide to Getting and Keeping Health Insurance in Missouri,” January 2006, <http://www.healthinsuranceinfo.net/mo00.html>

(2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. In Missouri, a woman who received Medicaid during her pregnancy and would have lost coverage 60 days postpartum is eligible to receive family planning services for up to one year. (This waiver expires on March 1, 2007).⁵

⁵ The Alan Guttmacher Institute, "Medicaid Family Planning Waivers," *State Policies in Brief* (November 1, 2006).

Cuts to Medicaid Will Hurt Missouri's Women

Federal and State Reforms to Medicaid Amount to Drastic Cuts

Medicaid is a vital source of insurance for millions of low-income Americans. The program currently provides health insurance coverage to nearly 55 million parents, children, pregnant women, elderly and people with disabilities. For those individuals that qualify, who are the poorest among us, Medicaid provides coverage for a panoply of important health care services, including physician and hospital care, preventive screenings, pregnancy-related care, contraceptive coverage and long-term care services. Medicaid provides these services in an efficient manner; in the wake of a health insurance market that has seen dramatically rising costs, Medicaid's costs have grown at *half the rate* of private insurers.¹

Yet, policy makers on both the federal and state levels have called for "reforms" to the Medicaid program. President Bush has consistently supported limiting funding for the Medicaid program and has even proposed capping federal funding to the states. Congress has followed with major legislative changes that allow states to limit benefit packages and charge beneficiaries more for their care. Some states have applied to the federal government for very broad waivers in order to get out of certain federal requirements that guarantee benefits and restrict cost-sharing. The loss of these federal protections leaves many beneficiaries vulnerable to severe benefit reductions, high out of pocket costs and even removal from the program.

Why Do These Cuts Matter to Missouri Women?

Medicaid in Missouri provides health care services to low-income women, who comprise **70% of beneficiaries age 19 and older**.¹ Women are *twice* as likely as men to qualify for Medicaid because they are poorer and more likely to meet the stringent eligibility criteria and because they are in lower paying jobs that are less likely to come with employer-sponsored insurance. Health insurance is critical to women because mothers with health insurance are more likely to stay employed and get health care for their children than those lacking insurance.

Missouri Women Rely on Medicaid for a Range of Services

- *Very low-income parents* with dependent children and incomes up to 40% of the federal poverty level (FPL), or roughly \$556 a month for a family of three, can get comprehensive services.² These services help keep these women healthy, which allows them to take care of their families and remain in the workforce.
- *Low-income pregnant women* with incomes up 185% of FPL, or roughly \$1,511 a month for an individual, can get prenatal care. In Missouri, **40.5% of all births in the state are paid for by Medicaid**.
- *Low-income disabled and aged people* are eligible for Medicaid if their incomes are at or below 100% of FPL, or roughly \$817 a month for an individual. These beneficiaries rely on Medicaid for both comprehensive care and long-term services, the latter of which are extremely costly and

¹ John Holahan and Arunabh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

can have a devastating financial impact on women with fixed incomes. Medicaid is the largest source of funding for people in nursing homes, who tend to be women over 80 without a spouse or close relative living in their community.

- *Low-income uninsured women who have breast and cervical cancer* and who are diagnosed through the CDC screening program can receive treatment for their illness if they are at least 35 years old and if their income is below 200% of FPL, or roughly \$1,634 a month for an individual.³
- *Low-income women in need of family planning* who received Medicaid during their pregnancy and would have lost Medicaid coverage after 60 days postpartum can receive family planning services for up to one year. These services include medical examinations, contraceptive prescriptions and counseling, sterilization, and STD testing and treatment.⁴

Missouri Depends on the Federal Government for 62% of Program Costs

In Missouri, the Medicaid program is run jointly by the federal, state and county governments. The federal government contributes a share of the program's costs, based on the per capita income in the state. The federal share of costs in Missouri is 62%. **Total Medicaid costs for the program in 2005 will be nearly \$6.6 billion, \$4 billion of which will come from the federal government.**⁵

Medicaid Is Cost Effective

Medicaid is more efficient than traditional private health insurance programs. **Medicaid spends 30% less per adult than private coverage.**⁶ **Also, Medicaid costs have been growing at slightly more than half the rate of the cost of private insurance,**⁷ despite the fact that Medicaid faces increased enrollment during weak economic times.

Budget Cuts Will Hurt Missouri's Medicaid Program

The cuts to Medicaid in the federal budget will result in a loss of health coverage for women and their families in Missouri. States will be receiving less federal funding for their programs and will be forced to cut eligibility and/or eliminate or cap services in order to recover from this loss. Even without the loss created by this significant reduction in federal funds, many states have been considering Medicaid cuts of their own. For women in these states, the loss of federal funds will be even more devastating.

¹ Kaiser Commission on Medicaid and the Uninsured analysis of 2001 MSIS data.

² Unless otherwise noted, all state facts are from Kaiser Family foundation State Health Facts online, available at <http://www.statehealthfacts.org>. All references to the federal poverty level are for 2006. <http://aspe.hhs.gov/poverty/05poverty.shtml>.

³ "A Consumer's Guide to Getting and Keeping Health Insurance in Missouri," available at <http://www.healthinsuranceinfo.net/mo05.html>.

⁴ Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services: Results of a National Survey* (Menlo Park: The Henry J. Kaiser Family Foundation, November 2001), 60, available at <http://www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13737>.

⁵ Families USA, "Medicaid Cuts are Bad Medicine: Missouri," January 2005, available at http://www.familiesusa.org/site/DocServer/Medicaid_cuts_Missouri.pdf?docID=5636.

⁶ Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, Winter 2003/2004.

⁷ John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-20003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003, available at <http://www.kff.org/insurance/ehbs2003-abstract.cfm>.

Health Care for the Poor: Who Is Eligible for Medicaid in Montana

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.¹ Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

Income Eligible Groups under Medicaid:

- (1) **Children** – A child up to age 6 becomes eligible with an income at or below \$1,839/month. A child between 6 and 19 qualifies if their family income is \$1,383/month.
- (2) **Parents** – A non-working parent becomes eligible for Medicaid if he or she resides in a family of 3 with an income of roughly \$512/month. A working parent in a family of 3 is eligible with an income of roughly \$854/month.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$1,839/month for her family of 3. Coverage extends throughout the pregnancy and for 60 days postpartum. Montana could opt to cover women whose income is up to \$2,559/month and still receive a federal match.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below roughly \$605/month, the income standard used to determine eligibility for Supplemental Security Income (SSI).²
- (5) **Elderly Populations** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their incomes are low enough. Seniors can get coverage for the full Medicaid benefits package plus assistance with Medicare premiums and cost-sharing or just the latter. An elderly individual qualifies for Medicaid if his/her income is at or below \$605/month.

Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.³ Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women between the ages of 50 and 64 with breast or cervical cancer who have been screened by the Centers for Disease Control and

¹ There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets.

² There is one notable exception to this minimum income level. Some states exercise what is known as a 209(b) option which allows states to use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972.

³ To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

Prevention (CDC) and do not have other health care coverage may receive treatment for their illness if their individual income is below \$1,634/month.⁴

- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. Montana does not have a family planning waiver.⁵

⁴ Georgetown University Health Policy Institute "A Consumer's Guide to Getting and Keeping Health Insurance in Montana," January 2006, <http://www.healthinsuranceinfo.net/mt00.html>

⁵ The Alan Guttmacher Institute, "Medicaid Family Planning Waivers," *State Policies in Brief* (November 1, 2006).

Cuts to Medicaid Will Hurt Montana's Women

Federal and State Reforms to Medicaid Amount to Drastic Cuts

Medicaid is a vital source of insurance for millions of low-income Americans. The program currently provides health insurance coverage to nearly 55 million parents, children, pregnant women, elderly and people with disabilities. For those individuals that qualify, who are the poorest among us, Medicaid provides coverage for a panoply of important health care services, including physician and hospital care, preventive screenings, pregnancy-related care, contraceptive coverage and long-term care services. Medicaid provides these services in an efficient manner; in the wake of a health insurance market that has seen dramatically rising costs, Medicaid's costs have grown at *half the rate* of private insurers.¹

Yet, policy makers on both the federal and state levels have called for "reforms" to the Medicaid program. President Bush has consistently supported limiting funding for the Medicaid program and has even proposed capping federal funding to the states. Congress has followed with major legislative changes that allow states to limit benefit packages and charge beneficiaries more for their care. Some states have applied to the federal government for very broad waivers in order to get out of certain federal requirements that guarantee benefits and restrict cost-sharing. The loss of these federal protections leaves many beneficiaries vulnerable to severe benefit reductions, high out of pocket costs and even removal from the program.

Why Do These Cuts Matter to Montana's Women?

Medicaid in Montana provides vital health care services to low-income women, who comprise **67% of beneficiaries age 19 and older**.² Women are *twice* as likely as men to qualify for Medicaid because they are poorer and more likely to meet the stringent eligibility criteria and because they are in lower paying jobs that are less likely to come with employer-sponsored insurance. Health insurance is critical to women because mothers with health insurance are more likely to stay employed and get health care for their children than those lacking insurance.

Montana Women Rely on Medicaid for a Range of Services

- *Very low-income parents* with dependent children and incomes up to 62% of the federal poverty level (FPL), or roughly \$854 a month for a family of three, can get comprehensive services.³ These services help keep these women healthy, which allows them to take care of their families and remain in the workforce.
- *Low-income pregnant women*, with incomes up to 133% of FPL or roughly \$1,087 a month for an individual, can get prenatal care. In Montana, **37.1% of all births in the state are paid for by Medicaid**.

¹ John Holahan and Arunabh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

² Kaiser Commission on Medicaid and the Uninsured analysis of 2001 MSIS data.

³ Unless otherwise noted, all state facts are from Kaiser Family Foundation State Health Facts online, available at <http://www.statehealthfacts.org>. All references to the federal poverty level are for 2006. <http://aspe.hhs.gov/poverty/05poverty.shtml>.

- *Low-income disabled and aged people* are eligible for Medicaid if their incomes are at or below 74% of FPL, or roughly \$605 a month for an individual. These beneficiaries rely on Medicaid for both comprehensive care and long-term services, the latter of which are extremely costly and can have a devastating financial impact on women with fixed incomes. Medicaid is the largest source of funding for people in nursing homes, who tend to be women over 80 without a spouse or close relative living in their community.
- *Low-income women who have breast and cervical cancer* and who are diagnosed through the CDC screening program can receive treatment for their illness if they are between the ages of 50 and 64 and their income is at or below 200% of FPL, or roughly \$1,634 a month for an individual.⁴
- *Low-income women in need of family planning* can receive these vital reproductive health services if they qualify for Medicaid. Family planning, which is a mandatory service, includes examinations by health care providers, lab tests, surgical procedures, supplies, contraception, and natural family planning methods.⁵

Montana Depends on the Federal Government for 69% of Program Costs

In Montana, the Medicaid program is run jointly by the federal, state and county governments. The federal government contributes a share of the program's costs, based on the per capita income in the state. The federal share of costs in Montana is 69%. **Total Medicaid costs for the program in 2005 will be nearly \$663 million, \$498 million of which will come from the federal government.**⁶

Medicaid Is Cost Effective

Medicaid is more efficient than traditional private health insurance programs. **Medicaid spends 30% less per adult than private coverage.⁷ Also, Medicaid costs have been growing at slightly more than half the rate of the cost of private insurance,⁸** despite the fact that Medicaid faces increased enrollment during weak economic times.

Budget Cuts Will Hurt Montana's Medicaid Program

The cuts to Medicaid in the federal budget will result in a loss of health coverage for women and their families in Montana. States will be receiving less federal funding for their programs and will be forced to cut eligibility and/or eliminate or cap services in order to recover from this loss. Even without the loss created by this significant reduction in federal funds, many states have been considering Medicaid cuts of their own. For women in these states, the loss of federal funds will be even more devastating.

⁴ <http://www.healthinsuranceinfo.net/mt.pdf>.

⁵ <http://www.dphhs.state.mt.us/hpsd/pubheal/healsafe/womheal/famplan.htm>.

⁶ Families USA, "Medicaid Cuts Are Bad Medicine: Montana," January 2005, available at http://www.familiesusa.org/site/DocServer/Medicaid_cuts_Montana.pdf?docID=5637.

⁷ Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, Winter 2003/2004.

⁸ John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-20003," *Health Affairs Web Exclusive W5*, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003, available at <http://www.kff.org/insurance/ehbs2003-abstract.cfm>.

Health Care for the Poor: Who Is Eligible for Medicaid in New Jersey

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.¹ Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

Income Eligible Groups under Medicaid:

- (1) **Children** – An infant less than one year old becomes eligible by residing in a family of 3 with an income at or below \$2,766/month. A child up to age 6 becomes eligible with an income at or below \$1,839/month. A child between 6 and 19 qualifies if their family income is \$1,839/month.
- (2) **Parents** – A non-working parent becomes eligible for Medicaid if he or she resides in a family of 3 with an income of roughly \$1,591/month. A working parent in a family of 3 is also eligible with an income of roughly \$1,590/month.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,766/month for her family of 3. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below roughly \$605/month, the income standard used to determine eligibility for Supplemental Security Income (SSI).²
- (5) **Elderly Populations** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their incomes are low enough. Seniors can get coverage for the full Medicaid benefits package plus assistance with Medicare premiums and cost-sharing or just the latter. Because these standards mirror those of the SSI program, an elderly individual also qualifies for Medicaid if his/her income is at or below \$605/month.

Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.³ Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women between the ages of 17 and 65 with breast or cervical cancer who have been screened by the Centers for Disease Control and

¹ There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets.

² There is one notable exception to this minimum income level. Some states exercise what is known as a 209(b) option which allows states to use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972.

³ To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

Prevention (CDC) and have no or limited health care coverage may receive treatment for their illness if their individual income is below \$2,042/month.⁴

- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. New Jersey does not have a family planning waiver.⁵

⁴Georgetown University Health Policy Institute A Consumer's Guide to Getting and Keeping Health Insurance in New Jersey January 2006, p. 34 <http://www.healthinsuranceinfo.net/nj00.html>

⁵ The Alan Guttmacher Institute, "Medicaid Family Planning Waivers," *State Policies in Brief* (November 1, 2006).

Cuts to Medicaid Will Hurt New Jersey's Women

Federal and State Reforms to Medicaid Amount to Drastic Cuts

Medicaid is a vital source of insurance for millions of low-income Americans. The program currently provides health insurance coverage to nearly 55 million parents, children, pregnant women, elderly and people with disabilities. For those individuals that qualify, who are the poorest among us, Medicaid provides coverage for a panoply of important health care services, including physician and hospital care, preventive screenings, pregnancy-related care, contraceptive coverage and long-term care services. Medicaid provides these services in an efficient manner; in the wake of a health insurance market that has seen dramatically rising costs, Medicaid's costs have grown at *half the rate* of private insurers.¹

Yet, policy makers on both the federal and state levels have called for "reforms" to the Medicaid program. President Bush has consistently supported limiting funding for the Medicaid program and has even proposed capping federal funding to the states. Congress has followed with major legislative changes that allow states to limit benefit packages and charge beneficiaries more for their care. Some states have applied to the federal government for very broad waivers in order to get out of certain federal requirements that guarantee benefits and restrict cost-sharing. The loss of these federal protections leaves many beneficiaries vulnerable to severe benefit reductions, high out of pocket costs and even removal from the program.

Why Do These Cuts Matter to New Jersey Women?

Medicaid in New Jersey provides vital health care services to low-income women, who comprise **72% of beneficiaries age 19 and older.**² Women are *twice* as likely as men to qualify for Medicaid because they are poorer and more likely to meet the stringent eligibility criteria and because they are in lower paying jobs that are less likely to come with employer-sponsored insurance. Health insurance is critical to women because mothers with health insurance are more likely to stay employed and get health care for their children than those lacking insurance.

New Jersey Women Rely on Medicaid for a Range of Services

- *Very low-income parents* with dependent children and incomes up to 115% of the federal poverty level (FPL), or roughly \$1,591 a month for a family of three, can get comprehensive services.³ These services help keep these women healthy, which allows them to take care of their families and remain in the workforce.
- *Low-income pregnant women*, with incomes up to 200% of FPL or roughly \$1,634 a month for an individual, can get prenatal care. In New Jersey, **24.2% of all births in the state are paid for by Medicaid.**

¹ John Holahan and Arunabh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

² Kaiser Commission on Medicaid and the Uninsured analysis of 2001 MSIS data.

³ Unless otherwise noted, all state facts are from Kaiser Family Foundation State Health Facts online, available at <http://www.statehealthfacts.org>. All references to the federal poverty level are for 2006. <http://aspe.hhs.gov/poverty/05poverty.shtml>.

- *Low-income disabled and aged people* are eligible for Medicaid if their incomes are at or below 100% of FPL, or roughly \$817 a month for an individual. These beneficiaries rely on Medicaid for both comprehensive care and long-term services, the latter of which are extremely costly and can have a devastating financial impact on women with fixed incomes. Medicaid is the largest source of funding for people in nursing homes, who tend to be women over 80 without a spouse or close relative living in their community.
- *Low-income women who have breast and cervical cancer* and who are diagnosed through the CDC screening program can receive treatment for their illness if their income is at or below 250% of FPL, or roughly \$2,042 a month for an individual. To be screened for breast cancer a woman must be between the ages 40-65 and to be screened for cervical cancer a woman must be between the ages 50-64.⁴
- *Low-income women in need of family planning* can receive these vital reproductive health services if they qualify for Medicaid. In New Jersey, family planning, which is a mandatory service, includes pregnancy prevention and testing, counseling, and sterilization.⁵

New Jersey Depends on the Federal Government for 50% of Program Costs

In New Jersey, the Medicaid program is run jointly by the federal, state and county governments. The federal government contributes a share of the program's costs, based on the per capita income in the state. The federal share of costs in New Jersey is 50%. **Total Medicaid costs for the program in 2005 will be nearly \$9.1 billion, \$4.6 billion of which will come from the federal government.**⁶

Medicaid Is Cost Effective

Medicaid is more efficient than traditional private health insurance programs. **Medicaid spends 30% less per adult than private coverage.⁷ Also, Medicaid costs have been growing at slightly more than half the rate of the cost of private insurance,⁸** despite the fact that Medicaid faces increased enrollment during weak economic times.

Budget Cuts Will Hurt New Jersey's Medicaid Program

The cuts to Medicaid in the federal budget will result in a loss of health coverage for women and their families in New Jersey. States will be receiving less federal funding for their programs and will be forced to cut eligibility and/or eliminate or cap services in order to recover from this loss. Even without the loss created by this significant reduction in federal funds, many states have been considering Medicaid cuts of their own. For women in these states, the loss of federal funds will be even more devastating.

⁴ <http://www.healthinsuranceinfo.net/nj05.html>

⁵ <http://www.hrsa.gov/tpr/states/New-Jersey-Medicaid-Covered-Services.htm>

⁶ Families USA, "Medicaid Cuts are Bad Medicine: New Jersey," January 2005, available at http://www.familiesusa.org/site/DocServer/Medicaid_cuts_New_Jersey.pdf?docID=5621.

⁷ Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, Winter 2003/2004.

⁸ John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-20003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003, available at <http://www.kff.org/insurance/ehbs2003-abstract.cfm>.

Health Care for the Poor: Who Is Eligible for Medicaid in South Carolina

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.¹ Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

Income Eligible Groups under Medicaid:

- (1) **Children** – An infant less than one year old becomes eligible by residing in a family of 3 with an income at or below \$2,075/month. A child up to age 19 becomes eligible with an income at or below \$2,559/month.
- (2) **Parents** – A parent becomes eligible for Medicaid if he or she resides in a family of three with an income of roughly \$1,340/month.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,559/month for her family of 3. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below \$605/month, the income standard used to determine eligibility for Supplemental Security Income (SSI).²
- (5) **Elderly Populations** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their incomes are low enough. Seniors can get coverage for the full Medicaid benefits package plus assistance with Medicare premiums and cost-sharing or just the latter. Because these standards mirror those of the SSI program, an elderly individual also qualifies for Medicaid if his/her income is at or below \$605/month.

Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.³ Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women between the ages of 50 and 64 with breast cancer and women between the ages of 18 and 64 with cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC) and do not have

¹ There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets.

² There is one notable exception to this minimum income level. Some states exercise what is known as a 209(b) option which allows states to use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972.

³ To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

other health care coverage may qualify for the basic Medicaid benefits package if their individual income is up to roughly \$1,634/month.⁴

- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. In South Carolina, women who otherwise are not eligible for Medicaid can get access to these services. Women with individual incomes at or below roughly \$1,511 a month can get coverage for family planning services.⁵

⁴ Georgetown University Health Policy Institute "A Consumer's Guide to Getting and Keeping Health Insurance South Carolina," December 2004, <http://www.healthinsuranceinfo.net/sc.pdf>

⁵ The Alan Guttmacher Institute, "Medicaid Family Planning Waivers," *State Policies in Brief* (November 1, 2006).

Cuts to Medicaid Will Hurt South Carolina's Women

Federal and State Reforms to Medicaid Amount to Drastic Cuts

Medicaid is a vital source of insurance for millions of low-income Americans. The program currently provides health insurance coverage to nearly 55 million parents, children, pregnant women, elderly and people with disabilities. For those individuals that qualify, who are the poorest among us, Medicaid provides coverage for a panoply of important health care services, including physician and hospital care, preventive screenings, pregnancy-related care, contraceptive coverage and long-term care services. Medicaid provides these services in an efficient manner; in the wake of a health insurance market that has seen dramatically rising costs, Medicaid's costs have grown at *half the rate* of private insurers.¹

Yet, policy makers on both the federal and state levels have called for "reforms" to the Medicaid program. President Bush has consistently supported limiting funding for the Medicaid program and has even proposed capping federal funding to the states. Congress has followed with major legislative changes that allow states to limit benefit packages and charge beneficiaries more for their care. Some states have applied to the federal government for very broad waivers in order to get out of certain federal requirements that guarantee benefits and restrict cost-sharing. The loss of these federal protections leaves many beneficiaries vulnerable to severe benefit reductions, high out of pocket costs and even removal from the program.

Why Do These Cuts Matter to South Carolina Women?

Medicaid in South Carolina provides vital health care services to low-income women, who comprise **79% of beneficiaries age 19 and older**.² Women are *twice* as likely as men to qualify for Medicaid because they are poorer and more likely to meet the stringent eligibility criteria and because they are in lower paying jobs that are less likely to come with employer-sponsored insurance. Health insurance is critical to women because mothers with health insurance are more likely to stay employed and get health care for their children than those lacking insurance.

South Carolina Women Rely on Medicaid for a Range of Services

- *Very low-income parents* with dependent children and incomes up to 97% of the federal poverty level (FPL), or roughly \$1,340 a month for a family of three, can get comprehensive services.³ These services help keep these women healthy, which allows them to take care of their families and remain in the workforce.
- *Low-income pregnant women*, with incomes up to 185% of FPL or roughly \$1,511 a month for an individual, can get prenatal care. In South Carolina, **45.2% of all births in the state are paid for by Medicaid**.

¹ John Holahan and Arunabh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

² Kaiser Commission on Medicaid and the Uninsured analysis of 2001 MSIS data.

³ Unless otherwise noted, all state facts are from Kaiser Family Foundation State Health Facts online, available at <http://www.statehealthfacts.org>. All references to the federal poverty level are for 2006. <http://aspe.hhs.gov/poverty/05poverty.shtml>.

- *Low-income disabled and aged people* are eligible for Medicaid if their incomes are at or below 100% of FPL, or roughly \$817 a month for an individual. These beneficiaries rely on Medicaid for both comprehensive care and long-term services, the latter of which are extremely costly and can have a devastating financial impact on women with fixed incomes. Medicaid is the largest source of funding for people in nursing homes, who tend to be women over 80 without a spouse or close relative living in their community.
- *Low-income women who have breast and cervical cancer* and who are diagnosed through the CDC screening program can receive treatment for their illness if their income is at or below 200% of FPL, or roughly \$1,634 a month for an individual. To be screened for breast cancer a woman must be between the ages of 50 and 64 and to be screened for cervical cancer a woman must be between the ages of 18 and 64.⁴
- *Low-income women in need of family planning* who otherwise are not eligible for Medicaid can get access to these services. Women with incomes at or below 185% of FPL, or roughly \$1,511 a month for an individual, can get coverage for contraception, sterilization, gynecological care, and STD testing and treatment.⁵

South Carolina Depends on the Federal Government for 69.5% of Program Costs

In South Carolina, the Medicaid program is run jointly by the federal, state and county governments. The federal government contributes a share of the program's costs, based on the per capita income in the state. The federal share of costs in South Carolina is 69.5%. **Total Medicaid costs for the program in 2005 will be nearly \$3.9 billion, \$2.7 billion of which will come from the federal government.**⁶

Medicaid Is Cost Effective

Medicaid is more efficient than traditional private health insurance programs. **Medicaid spends 30% less per adult than private coverage.**⁷ **Also, Medicaid costs have been growing at slightly more than half the rate of the cost of private insurance,**⁸ despite the fact that Medicaid faces increased enrollment during weak economic times.

Budget Cuts Will Hurt South Carolina's Medicaid Program

The cuts to Medicaid in the federal budget will result in a loss of health coverage for women and their families in South Carolina. States will be receiving less federal funding for their programs and will be forced to cut eligibility and/or eliminate or cap services in order to recover from this loss. Even without the loss created by this significant reduction in federal funds, many states have been considering Medicaid cuts of their own. For women in these states, the loss of federal funds will be even more devastating.

⁴ <http://www.healthinsuranceinfo.net/sc.pdf>

⁵ Kaiser Family Foundation, *Medicaid Coverage of Family Planning Services: Results of a National Survey* (Menlo Park: The Henry J. Kaiser Family Foundation, November 2001), 15-24, available at <http://www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13737>.

⁶ Families USA, "Medicaid Cuts are Bad Medicine: South Carolina," January 2005, available at http://www.familiesusa.org/site/DocServer/Medicaid_cuts_South_Carolina.pdf?docID=5621.

⁷ Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, Winter 2003/2004.

⁸ John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-20003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003, available at <http://www.kff.org/insurance/ehbs2003-abstract.cfm>.

Health Care for the Poor: Who Is Eligible for Medicaid in Utah

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.¹ Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

Income Eligible Groups under Medicaid:

- (1) **Children** – A child up to age 6 becomes eligible with an income at or below \$1,839/month. A child between 6 and 19 qualifies if their family income is \$1,383/month.
- (2) **Parents** – A non-working parent becomes eligible for Medicaid if he or she resides in a family of 3 with an income of roughly \$595/month. A working parent in a family of 3 is eligible with an income of roughly \$673/month.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$1,839/month for her family of 3. Coverage extends throughout the pregnancy and for 60 days postpartum. Utah could opt to cover women whose income is up to \$2,559/month and still receive a federal match.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below roughly \$605/month, the income standard used to determine eligibility for Supplemental Security Income (SSI).²
- (5) **Elderly Populations** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their incomes are low enough. Seniors can get coverage for the full Medicaid benefits package plus assistance with Medicare premiums and cost-sharing or just the latter. An elderly individual qualifies for Medicaid if his/her income is at or below \$605/month.

Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.³ Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women between the ages of 50 and 64 with breast or cervical cancer who have been screened by the Centers for Disease Control and

¹ There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets.

² There is one notable exception to this minimum income level. Some states exercise what is known as a 209(b) option which allows states to use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972.

³ To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

Prevention (CDC) and do not have other health care coverage may receive treatment for their illness if their individual income is below \$2,042/month.⁴

- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. Utah does not have a family planning waiver.⁵

⁴ Georgetown University Health Policy Institute "A Consumer's Guide to Getting and Keeping Health Insurance in Utah," December 2004, <http://www.healthinsuranceinfo.net/ut00.html>

⁵ The Alan Guttmacher Institute, "Medicaid Family Planning Waivers," *State Policies in Brief* (November 1, 2006).

Cuts to Medicaid Will Hurt Utah's Women

Federal and State Reforms to Medicaid Amount to Drastic Cuts

Medicaid is a vital source of insurance for millions of low-income Americans. The program currently provides health insurance coverage to nearly 55 million parents, children, pregnant women, elderly and people with disabilities. For those individuals that qualify, who are the poorest among us, Medicaid provides coverage for a panoply of important health care services, including physician and hospital care, preventive screenings, pregnancy-related care, contraceptive coverage and long-term care services. Medicaid provides these services in an efficient manner; in the wake of a health insurance market that has seen dramatically rising costs, Medicaid's costs have grown at *half the rate* of private insurers.¹

Yet, policy makers on both the federal and state levels have called for "reforms" to the Medicaid program. President Bush has consistently supported limiting funding for the Medicaid program and has even proposed capping federal funding to the states. Congress has followed with major legislative changes that allow states to limit benefit packages and charge beneficiaries more for their care. Some states have applied to the federal government for very broad waivers in order to get out of certain federal requirements that guarantee benefits and restrict cost-sharing. The loss of these federal protections leaves many beneficiaries vulnerable to severe benefit reductions, high out of pocket costs and even removal from the program.

Why Do These Cuts Matter to Utah Women?

Medicaid in Utah provides vital health care services to low-income women, **who comprise 75% of beneficiaries age 19 and older.**² Women are *twice* as likely as men to qualify for Medicaid because they are poorer and more likely to meet the stringent eligibility criteria and because they are in lower paying jobs that are less likely to come with employer-sponsored insurance. Health insurance is critical to women because mothers with health insurance are more likely to stay employed and get health care for their children than those lacking insurance.

Utah Women Rely on Medicaid for a Range of Services

- *Very low-income parents* with dependent children and incomes up to 49% FPL,³ or roughly \$673 a month for a family of three.⁴ These services help keep these women healthy, which allows them to take care of their families and remain in the workforce.

¹ John Holahan and Arunabh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

² Kaiser Commission on Medicaid and the Uninsured analysis of 2001 MSIS data.

³ Utah has a waiver program called the Primary Care Network which provides limited benefits to uninsured adults under 150% of FPL. Coverage does not include specialty care or inpatient hospital care and all services come with high co-payments.

⁴ Unless otherwise noted, all state facts are from Kaiser Family Foundation State Health Facts online, available at <http://www.statehealthfacts.org>. All references to the federal poverty level are for 2005. <http://aspe.hhs.gov/poverty/05poverty.shtml>.

- *Low-income pregnant women*, with incomes up to 133% of FPL or roughly \$1,087 a month for an individual, can get prenatal care. In Utah, **26.6% of all births in the state are paid for by Medicaid.**
- *Low-income disabled and aged people* are eligible for Medicaid if their incomes are at or below 100% of FPL, or roughly \$605 a month for an individual. These beneficiaries rely on Medicaid for both comprehensive care and long-term services, the latter of which are extremely costly and can have a devastating financial impact on women with fixed incomes. Medicaid is the largest source of funding for people in nursing homes, who tend to be women over 80 without a spouse or close relative living in their community.
- *Low-income women who have breast and cervical cancer* and who are diagnosed through the CDC screening program can receive treatment for their illness if they are between the ages of 50 and 64 and their income is at or below 250% of FPL, or roughly \$2,042 a month for an individual.⁵
- *Low-income women in need of family planning* can receive these vital reproductive health services if they qualify for Medicaid. In Utah, family planning, which is a mandatory service, includes diagnosis, treatment, drugs, supplies and related counseling that are provided to individuals of childbearing age to enable the individuals to determine freely the number and spacing of their children. Services also include STD testing, counseling and treatment

Utah Depends on the Federal Government for 70% of Program Costs

In Utah, the Medicaid program is run jointly by the federal, state and county governments. The federal government contributes a share of the program's costs, based on the per capita income in the state. The federal share of costs in Utah is 70%. **Total Medicaid costs for the program in 2005 will be more than \$1.4 billion, \$1 billion of which will come from the federal government.**⁶

Medicaid Is Cost Effective

Medicaid is more efficient than traditional private health insurance programs. **Medicaid spends 30% less per adult than private coverage.**⁷ **Also, Medicaid costs have been growing at slightly more than half the rate of the cost of private insurance,**⁸ despite the fact that Medicaid faces increased enrollment during weak economic times.

Budget Cuts Will Hurt Utah's Medicaid Program

The cuts to Medicaid in the federal budget will result in a loss of health coverage for women and their families in Utah. States will be receiving less federal funding for their programs and will be forced to cut eligibility and/or eliminate or cap services in order to recover from this loss. Even without the loss created by this significant reduction in federal funds, many states have been considering Medicaid cuts of their own. For women in these states, the loss of federal funds will be even more devastating.

⁵ <http://www.healthinsuranceinfo.net/ut05.html>.

⁶ Families USA, "Medicaid Cuts Are Bad Medicine," January 2005, available at http://www.familiesusa.org/site/DocServer/Medicaid_cuts_Utah.pdf?docID=5651.

⁷ Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, Winter 2003/2004.

⁸ John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-20003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003, available at <http://www.kff.org/insurance/ehbs2003-abstract.cfm>.

Health Care for the Poor: Who Is Eligible for Medicaid in Vermont

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.¹ Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

Income Eligible Groups under Medicaid:

- (1) **Children** – A child up to age 19 becomes eligible by residing in a family of 3 with an income at or below \$4,149/month.
- (2) **Parents** – A non-working parent becomes eligible for Medicaid if he or she resides in a family of 3 with an income of roughly \$2,559/month. A working parent in a family of 3 is eligible with an income of roughly \$2,649/month.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,766/month for her family of 3. If her monthly income is above \$2,559, she will have to pay a premium. Coverage extends throughout the pregnancy and for 60 days postpartum.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below roughly \$605/month, the income standard used to determine eligibility for Supplemental Security Income (SSI).²
- (5) **Elderly Populations** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their incomes are low enough. Seniors can get coverage for the full Medicaid benefits package plus assistance with Medicare premiums and cost-sharing or just the latter. An elderly individual qualifies for Medicaid if his/her income is at or below \$605/month.

Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.³ Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** – *Low-income women who have breast and cervical cancer* and who are diagnosed through the CDC screening program can receive treatment for their illness if they are under 65 and they have a limited income. Women can receive breast or cervical cancer screenings for free if they are over the age of 40 (or

¹ There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets.

² There is one notable exception to this minimum income level. Some states exercise what is known as a 209(b) option which allows states to use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972.

³ To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

between 18 and 39 in some special cases) with an income at or below 250% of FPL, or roughly \$2,042 a month for an individual.⁴

- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. Vermont does not have a family planning waiver.⁵

⁴ <http://www.healthyvermonters.info/hs/epi/cdepi/cancer/ladiesfirst/about/join.html>

⁵ The Alan Guttmacher Institute, "Medicaid Family Planning Waivers," *State Policies in Brief* (November 1, 2006).

Cuts to Medicaid Will Hurt Vermont's Women

Federal and State Reforms to Medicaid Amount to Drastic Cuts

Medicaid is a vital source of insurance for millions of low-income Americans. The program currently provides health insurance coverage to nearly 55 million parents, children, pregnant women, elderly and people with disabilities. For those individuals that qualify, who are the poorest among us, Medicaid provides coverage for a panoply of important health care services, including physician and hospital care, preventive screenings, pregnancy-related care, contraceptive coverage and long-term care services. Medicaid provides these services in an efficient manner; in the wake of a health insurance market that has seen dramatically rising costs, Medicaid's costs have grown at *half the rate* of private insurers.¹

Yet, policy makers on both the federal and state levels have called for "reforms" to the Medicaid program. President Bush has consistently supported limiting funding for the Medicaid program and has even proposed capping federal funding to the states. Congress has followed with major legislative changes that allow states to limit benefit packages and charge beneficiaries more for their care. Some states have applied to the federal government for very broad waivers in order to get out of certain federal requirements that guarantee benefits and restrict cost-sharing. The loss of these federal protections leaves many beneficiaries vulnerable to severe benefit reductions, high out of pocket costs and even removal from the program.

Why Do These Cuts Matter to Vermont Women?

Medicaid in Vermont provides vital health care services to low-income women, who comprise **62% of beneficiaries age 19 and older**.² Women are *twice* as likely as men to qualify for Medicaid because they are poorer and more likely to meet the stringent eligibility criteria and because they are in lower paying jobs that are less likely to come with employer-sponsored insurance. Health insurance is critical to women because mothers with health insurance are more likely to stay employed and get health care for their children than those lacking insurance.

Vermont Women Rely on Medicaid for a Range of Services

- *Very low-income parents* with dependent children and incomes up to 192% of the federal poverty level (FPL), or roughly \$2,649 a month for a family of three, can get comprehensive services.³ These services help keep these women healthy, which allows them to take care of their families and remain in the workforce.
- *Low-income pregnant women*, with incomes up to 200% of FPL or roughly \$1,634 a month for an individual, can get prenatal care. In Vermont, **43.2% of all births in the state are paid for by Medicaid**.

¹ John Holahan and Arunabh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

² Kaiser Commission on Medicaid and the Uninsured analysis of 2001 MSIS data.

³ Unless otherwise noted, all state facts are from Kaiser Family Foundation State Health Facts online, available at <http://www.statehealthfacts.org>. All references to the federal poverty level are for 2006. <http://aspe.hhs.gov/poverty/05poverty.shtml>.

- *Low-income disabled and aged people* are eligible for Medicaid if their incomes are at or below 74% of FPL, or roughly \$605 a month for an individual. These beneficiaries rely on Medicaid for both comprehensive care and long-term services, the latter of which are extremely costly and can have a devastating financial impact on women with fixed incomes. Medicaid is the largest source of funding for people in nursing homes, who tend to be women over 80 without a spouse or close relative living in their community.
- *Low-income women who have breast and cervical cancer* and who are diagnosed through the CDC screening program can receive treatment for their illness if they are under 65 and they have a limited income.⁴ Women can receive breast or cervical cancer screenings for free if they are over the age of 40 (or between 18 and 39 in some special cases) with an income at or below 250% of FPL, or roughly \$2,042 a month for an individual.⁵
- *Low-income women in need of family planning* can receive these vital reproductive health services if they qualify for Medicaid. Family planning, which is a mandatory service, includes physical exams, lab tests, surgical procedures, counseling, natural family planning methods, and sterilization.⁶

Vermont Depends on the Federal Government for 59% of Program Costs

In Vermont, the Medicaid program is run jointly by the federal, state and county governments. The federal government contributes a share of the program's costs, based on the per capita income in the state. The federal share of costs in Vermont is 59%. **Total Medicaid costs for the program in 2005 will be nearly \$900 million, \$540 million of which will come from the federal government.**⁷

Medicaid Is Cost Effective

Medicaid is more efficient than traditional private health insurance programs. **Medicaid spends 30% less per adult than private coverage.⁸ Also, Medicaid costs have been growing at slightly more than half the rate of the cost of private insurance,⁹** despite the fact that Medicaid faces increased enrollment during weak economic times.

Budget Cuts Will Hurt Vermont's Medicaid Program

The cuts to Medicaid in the federal budget will result in a loss of health coverage for women and their families in Vermont. States will be receiving less federal funding for their programs and will be forced to cut eligibility and/or eliminate or cap services in order to recover from this loss. Even without the loss created by this significant reduction in federal funds, many states have been considering Medicaid cuts of their own. For women in these states, the loss of federal funds will be even more devastating.

⁴ <http://www.healthinsuranceinfo.net/vt.pdf> (Vermont does not give out information about income eligibility limits).

⁵ <http://www.healthyvermonters.info/hs/epi/cdepi/cancer/ladiesfirst/about/join.html>

⁶ <http://www.hrsa.gov/tpr/states/Vermont-Medicaid-Covered-Services.htm>.

⁷ Families USA, "Medicaid Cuts are Bad Medicine: Vermont," January 2005, available at http://www.familiesusa.org/site/DocServer/Medicaid_cuts_Vermont.pdf?docID=5743.

⁸ Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, Winter 2003/2004.

⁹ John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-20003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003, available at <http://www.kff.org/insurance/ehbs2003-abstract.cfm>.

Health Care for the Poor: Who Is Eligible for Medicaid in West Virginia

Although Medicaid is known as public health insurance for the poor, only certain categories of the poor at certain income levels qualify for coverage under the program. The federal government sets “mandatory” income eligibility standards, but states can set higher “optional” income eligibility levels.¹ Under federal law, the state can still receive federal matching funds for covering populations at higher optional levels.

Income Eligible Groups under Medicaid:

- (1) **Children** – An infant less than one year old becomes eligible by residing in a family of 3 with an income at or below \$2,075/month. A child up to age 6 becomes eligible with an income at or below \$1,839/month. A child between 6 and 19 qualifies if their family income is \$1,383/month.
- (2) **Parents** – A non-working parent becomes eligible for Medicaid if he or she resides in a family of 3 with an income of roughly \$263/month. A working parent in a family of 3 is eligible with an income of roughly \$499/month.
- (3) **Pregnant Women** – A pregnant woman is eligible for Medicaid if her income is at or below \$2,075/month for her family of 3. Coverage extends throughout the pregnancy and for 60 days postpartum. West Virginia could opt to cover women whose income is up to \$2,559/month and still receive a federal match.
- (4) **People with Disabilities** – An individual with a disability generally qualifies for Medicaid if his/her income is at or below roughly \$605/month, the income standard used to determine eligibility for Supplemental Security Income (SSI).²
- (5) **Elderly Populations** – Individuals over 65 can qualify for both the Medicaid and Medicare programs if their incomes are low enough. Seniors can get coverage for the full Medicaid benefits package plus assistance with Medicare premiums and cost-sharing or just the latter. An elderly individual qualifies for Medicaid if his/her income is at or below \$605/month.

Service Eligible Groups Under Medicaid:

Additional eligibility categories have been established by the federal government for the state to pursue at its option.³ Two notable categories include:

- (1) **Breast and Cervical Cancer Patients** - Women under age 65 with breast or cervical cancer who have been screened by the Centers for Disease Control and Prevention (CDC)

¹ There are other components to Medicaid eligibility, including citizenship and residency requirements as well as limits on resources and assets.

² There is one notable exception to this minimum income level. Some states exercise what is known as a 209(b) option which allows states to use income, resource, and disability standards that are no more restrictive than those in place on January 1, 1972.

³ To learn more about all the optional eligibility categories in Medicaid, please see Kaiser Family Foundation, The Medicaid Resource Book, July 2002, Chapter 1 available at <http://www.kff.org/medicaid/2236-index.cfm>

and do not have other health care coverage may receive treatment for their illness if their individual income is below \$1,634/month.⁴

- (2) **Family Planning Expansion Populations** - States may obtain waivers to provide coverage of family planning services for individuals whose income is over the eligibility level for parent coverage but under the state's income eligibility for pregnancy. West Virginia does not have a family planning waiver.⁵

⁴ <http://www.hsc.wvu.edu/mbrc/bccsp/patient/services.htm>

⁵ The Alan Guttmacher Institute, "Medicaid Family Planning Waivers," *State Policies in Brief* (November 1, 2006).

Cuts to Medicaid Will Hurt West Virginia's Women

Federal and State Reforms to Medicaid Amount to Drastic Cuts

Medicaid is a vital source of insurance for millions of low-income Americans. The program currently provides health insurance coverage to nearly 55 million parents, children, pregnant women, elderly and people with disabilities. For those individuals that qualify, who are the poorest among us, Medicaid provides coverage for a panoply of important health care services, including physician and hospital care, preventive screenings, pregnancy-related care, contraceptive coverage and long-term care services. Medicaid provides these services in an efficient manner; in the wake of a health insurance market that has seen dramatically rising costs, Medicaid's costs have grown at *half the rate* of private insurers.¹

Yet, policy makers on both the federal and state levels have called for "reforms" to the Medicaid program. President Bush has consistently supported limiting funding for the Medicaid program and has even proposed capping federal funding to the states. Congress has followed with major legislative changes that allow states to limit benefit packages and charge beneficiaries more for their care. Some states have applied to the federal government for very broad waivers in order to get out of certain federal requirements that guarantee benefits and restrict cost-sharing. The loss of these federal protections leaves many beneficiaries vulnerable to severe benefit reductions, high out of pocket costs and even removal from the program.

Why Do These Cuts Matter to West Virginia Women?

Medicaid in West Virginia provides vital health care services to low-income women, who comprise **66% of beneficiaries age 19 and older**.² Women are *twice* as likely as men to qualify for Medicaid because they are poorer and more likely to meet the stringent eligibility criteria and because they are in lower paying jobs that are less likely to come with employer-sponsored insurance. Health insurance is critical to women because mothers with health insurance are more likely to stay employed and get health care for their children than those lacking insurance.

West Virginia Women Rely on Medicaid for a Range of Services

- *Very low-income parents* with dependent children and incomes up to 36% of the federal poverty level (FPL), or roughly \$499 a month for a family of three, can get comprehensive services.³ These services help keep these women healthy, which allows them to take care of their families and remain in the workforce.
- *Low-income pregnant women*, with incomes up to 150% of FPL or roughly \$1,226 a month for an individual, can get prenatal care. In West Virginia, **49.3% of all births in the state are paid for by Medicaid**.

¹ John Holahan and Arunabh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003.

² Kaiser Commission on Medicaid and the Uninsured analysis of 2001 MSIS data.

³ Unless otherwise noted, all state facts are from Kaiser Family Foundation State Health Facts online, available at <http://www.statehealthfacts.org>. All references to the federal poverty level are for 2006. <http://aspe.hhs.gov/poverty/05poverty.shtml>.

- *Low-income disabled and aged people* are eligible for Medicaid if their incomes are at or below 74% of FPL, or roughly \$605 a month for an individual. These beneficiaries rely on Medicaid for both comprehensive care and long-term services, the latter of which are extremely costly and can have a devastating financial impact on women with fixed incomes. Medicaid is the largest source of funding for people in nursing homes, who tend to be women over 80 without a spouse or close relative living in their community.
- *Low-income women who have breast and cervical cancer* and who are diagnosed through the CDC screening program can receive treatment for their illness if they are under 65 and their income is at or below 200% of FPL, or roughly \$1,634 a month for an individual.⁴
- *Low-income women in need of family planning* can receive these vital reproductive health services if they qualify for Medicaid. Family planning, which is a mandatory service, includes physical exams, lab tests, counseling, supplies, devices that prevent conception, and natural family planning methods.⁵

West Virginia Depends on the Federal Government for 73% of Program Costs

In West Virginia, the Medicaid program is run jointly by the federal, state and county governments. The federal government contributes a share of the program's costs, based on the per capita income in the state. The federal share of costs in West Virginia is currently 73%. **Total Medicaid costs for the program in 2005 will be nearly \$2.1 billion, \$1.6 billion of which will come from the federal government.**⁶

Medicaid Is Cost Effective

Medicaid is more efficient than traditional private health insurance programs. **Medicaid spends 30% less per adult than private coverage.**⁷ **Also, Medicaid costs have been growing at slightly more than half the rate of the cost of private insurance,**⁸ despite the fact that Medicaid faces increased enrollment during weak economic times.

Budget Cuts Will Hurt West Virginia's Medicaid Program

The cuts to Medicaid in the federal budget will result in a loss of health coverage for women and their families in West Virginia. States will be receiving less federal funding for their programs and will be forced to cut eligibility and/or eliminate or cap services in order to recover from this loss. Even without the loss created by this significant reduction in federal funds, many states have been considering Medicaid cuts of their own. For women in these states, the loss of federal funds will be even more devastating.

⁴ <http://www.hsc.wvu.edu/mbrcc/bccsp/patient/services.htm>.

⁵ <http://www.wvdhhr.org/mcfh/wvfp/services.asp>.

⁶ Families USA, "Medicaid Cuts are Bad Medicine: West Virginia," January 2005, available at http://www.familiesusa.org/site/DocServer/Medicaid_cuts_West_Virginia.pdf?docID=5714.

⁷ Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, Winter 2003/2004.

⁸ John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-20003," *Health Affairs Web Exclusive* W5, January 26, 2005, 52; The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey*, September 2003, available at <http://www.kff.org/insurance/ehbs2003-abstract.cfm>.

Medicaid Under Attack: What to Look For

Medicaid, the health insurance program for the poorest among us, is under attack from many directions. In monitoring the program this year, here are the key avenues to watch:

U.S. Congressional Action

- Congress has used its **statutory power to change the underlying requirements of the Medicaid law**. For example, the Deficit Reduction Act of 2005 stripped important protections away from beneficiaries by adding substantial and enforceable co-payments and documentation requirements, and by providing the states with increased “flexibility” to reduce benefits. More proposed cuts are possible in the fiscal 2007 budget.
- Other, non-budgetary legislation can impact Medicaid too. The **Federal Consent Decree Fairness Act** ([S. 489](#) and [H.R. 1229](#)), introduced in the 109th Congress, would allow government defendants to file a motion to vacate or modify court-approved lawsuit settlements, including settlements that ensure that a state is meeting its requirements under federal Medicaid law. This bill would undermine the effectiveness of consent decrees and could force beneficiaries to re-litigate their cases all over again every few years. Although this bill has implications for a broad range of issues, it was created to relieve Tennessee of its obligation to provide benefits to Medicaid recipients and has serious implications for Medicaid beneficiaries around the country. It is unclear whether it will be reintroduced in this Congress.

The Bush Administration Action

- The Center for Medicaid and Medicare Services (CMS) has used its authority to encourage states to drastically alter their Medicaid programs by selectively approving waivers geared toward health savings accounts, behavioral modification requirements and limited benefits packages.
- President Bush has pushed a health care agenda characterized by a heavy reliance on the private market. He has promoted the expansion of **health savings accounts** (HSAs), even in the context of Medicaid. In Medicaid, HSAs give the individual a small pot of money to use on health care before insurance coverage begins. The theory is that individuals will do better for themselves by having a limited amount of money to spend on their own health care as they see fit (i.e. “**consumer driven health care**”). To use an HSA, an individual must forgo a comprehensive health plan and instead use their HSA to cover care until their high-deductible plan kicks in. These accounts present several problems. First, rather than discouraging the overuse of services, HSAs could lead to the *under-use of needed services*, particularly for the low-income and those with chronic illnesses. Also, the level of consumer information

needed (namely about price, quality and effectiveness) for HSAs to function properly is not yet available.

- In 2005, the **Medicaid Commission** was created to recommend how the Medicaid program should be restructured so as to be less costly in the long term. Last month, the Commission released its final recommendations that, although troubling, are unlikely to be implemented by the new Democrat-controlled Congress. The Commission's work was highly controversial because **beneficiaries had virtually no voting representation on the Commission**. In fact, only two voting members of the Commission represent patients and one of them voted against the recommendations.

State Action

- **Waiver applications** allow states to get around federal Medicaid requirements. Sometimes, as with family planning waivers, this process is used to expand coverage. However, recently, states have used waivers to depart from critical coverage standards without much legislative oversight or public input. For example, in only *sixteen days*, the federal government reviewed and approved a waiver application from Florida which made sweeping and unprecedented changes to the program. **Waiver applications are now often used to turn traditional notions of insurance and risk-pooling on their heads**. For example, in South Carolina, the Governor's proposal would change Medicaid for many groups, including parents and pregnant women, from an insurance model that covers services as people need them to a set amount of money (a state version of an HSA) for each person. The amount of money for each person would not be based on that individual's actual health needs but on an average amount that could be too high or too low for that person. And the health plans that can participate would not be required to offer the range of benefits previously offered to adults under Medicaid. Given the speed with which the application process can move, it is essential to consider potential waivers as soon as they are circulated as concept papers. Also, it is important to insure that appropriate steps are taken to ensure public and legislative input in any waiver application.
- **State Plan Amendments (SPAs) Under the DRA**
Passage of the DRA made it much easier for states to amend their state Medicaid plans without submitting a waiver application. Instead, states may now implement Medicaid policy changes by filing a State Plan Amendment (SPA) using increased flexibility granted under the DRA. Any SPA that meets the federal statutory requirements must be approved and there is little opportunity for public input. For example, in only eight business days, the federal government reviewed and approved a SPA application from West Virginia which made sweeping and unprecedented changes to the program. The state implemented a two-tiered system that rewards beneficiaries who agree "to attend health improvement programs as directed," take prescription drugs, not go to the emergency room unless it's truly a medical emergency, and to keep appointments and have regular screenings will have access to

an “enhanced” benefits package that includes mental health, long-term care for chronic conditions like diabetes, and anti-obesity/anti-smoking classes. Those who do not agree to abide by the new rules will only have access to the federally mandated basic services and be limited to 4 prescriptions per month.¹

- ***Many changes can be made by the state which do not require a waiver but still have enormous implications for health coverage under Medicaid.*** In Missouri, where tens of thousands lost their coverage when the state dropped all optional parents and reverted to covering only those required by federal law. Parents faced the deepest cut instituted by any state in eligibility, from \$980 a month to just \$292 a month for a family of three. Other states have pushed the envelope even further in the name of containing costs. In Tennessee, changes were made to the state’s definition of “medical necessity” that has made it one of the most restrictive definitions in nation. The new definition only requires coverage for the “least costly” service that is “adequate” rather than the most cost-effective service that meets the accepted standard of care.
- ***States have also attempted expansions, though given budgetary constraints, expansions through Medicaid are few and far between.*** Several years ago, Utah expanded coverage for primary care services only to low-income uninsured parents and adults. This came at a price, however, as costs were offset by severely limiting benefits² and raising cost sharing for Medicaid-eligible parents, most of whom make under 54% of FPL. More recently, Vermont created an expansion, set for implementation in early 2007, which will cover adults up to 300% of FPL using a partially subsidized private coverage program known as Catamount Health. It allows those not eligible for public programs and without access to employer-sponsored insurance to buy into the program on a sliding-fee scale. However, because Vermont has a negotiated waiver with the federal government which includes an overall cap on federal funds, there is fear that Medicaid beneficiaries ultimately will face cuts if costs for either Medicaid or Catamount exceed what is expected in a given year.

¹ Erik Eckholm, *Medicaid Plan Prods Patients Toward Health*, New York Times, Dec. 1, 2006

² There are no hospitalization services for this population.

Ensuring Public Input on and Legislative Oversight of Medicaid

Background

Preserving Medicaid's critical healthcare coverage is integral to promoting autonomy and equality for millions of low-income women who rely on this vital safety net program to provide healthcare for their families. Fighting back against cuts in core Medicaid services and ensuring that beneficiaries maintain access to care requires greater legislative oversight and more meaningful public involvement at both the state and federal levels.

Both Section 1115 Medicaid waivers and State Plan Amendments ("SPAs") have enormous programmatic consequences for Medicaid beneficiaries, yet negotiations surrounding these vital changes are often conducted largely behind closed doors. Sometimes, as with family planning waivers, this process is used to expand coverage. However, recently, states have used waivers or SPAs to depart from critical coverage standards without much legislative oversight or public input. For example, after closed door negotiations, in only eight business days from the formal submission of the application, the federal government reviewed and approved a SPA application from West Virginia which made sweeping and unprecedented changes to the program. The federal government approved Florida's waiver, which included significant cuts in services, in just twelve business days. These "review" periods were too short to permit either legislative oversight or appropriate public comment, and they mark a significant reduction in the time taken by CMS to review major changes to healthcare programs. Out of ten Medicaid/SCHIP waivers submitted by states during 2000-2002, the average length of time for CMS approval was 5.5 months.¹

Process Concerns at the Federal Level

The Department of Health and Human Services (HHS) administers the waiver application and approval process through CMS. Although HHS established policies and procedures to provide public notice of waiver applications at both the federal and state levels in 1994, HHS has not provided a federal notice and comment period in compliance with the policy since 1998, and instead has relied on states to have a public process. In many cases, states have not released pending waivers when requested and only publish the waivers after approval.²

Members of Congress have attempted to address the lack of transparency in the federal waiver approval process through legislation. In 2002, Senator Max Baucus (D-MT) introduced a bill that included a provision to improve the development and implementation process of Medicaid and SCHIP waivers (S3018). This type of legislation at the federal level would increase the opportunity for meaningful public input by requiring both states and CMS to publish notices of

¹ Kaiser Commission on Medicaid and the Uninsured, "Section 1115 Waivers at a Glance: Summary of Recent Medicaid and SCHIP Waiver Activity," April 2003, Table 1: Status and Brief Description of Waivers."

² GAO Report, "Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns," July 12, 2002.

all waiver proposals and amendments and allow public comments within a certain time period. The legislation also requires the states to include projections regarding the likely impact on beneficiaries and healthcare providers in their proposals and to hold public hearings. Congress may also conduct oversight of CMS through its own staff and the use of hearings, or it may direct the Government Accountability Office (GAO) or the Office of Inspector General (OIG) to do so.³

Similar legislation may be introduced in the upcoming Congress that addresses the concerns raised by the DRA and incorporates the prior proposals involving waivers.

Process Concerns at the State Level

States implement Medicaid policy changes by filing a State Plan Amendment (SPA) or by applying for a waiver of changes that are not allowed under current law. At the state level there is great variation among states regarding the process for approval of state waivers to be submitted to CMS. In most states, the executive branch makes decisions about changes to the state Medicaid program and the development of SPA/waiver proposals unilaterally and just a small number of states require legislative approval or public notice for changes to the state Medicaid program.

The District of Columbia, Missouri, and New Hampshire all have provisions requiring *legislative approval* of both waivers and SPAs. Connecticut is the only state requiring *legislative approval* for SPAs but not waivers. Ten other states have a provision requiring *legislative approval* of waivers only (Colorado, Florida, Louisiana, Massachusetts, Montana, Nevada, North Dakota, Ohio, Oregon, and Wyoming). Kentucky and Nebraska require *notice* to the legislature regarding SPAs and several other states (Alaska, Minnesota, Ohio, and Vermont) have requirements for *legislative notice* and review of rule changes.⁴

States without legislative oversight or public input procedures could enact laws that require the state to notify the public about their SPA/waiver applications before it is submitted to CMS, publish SPA/waiver proposals to allow for public comment, hold public hearings, and include a summary of all public comments with the proposals upon submission. A model law could be found at http://www.nachc.com/advocacy/state-policy_modelleg.asp.

Achieving greater legislative oversight and public input at both the state and federal levels is critical to ensuring that beneficiaries will continue to play a meaningful role in the Medicaid reform process. Over the last few years, many significant cuts and changes in core benefits and services have threatened this vital safety net program, making it essential that the public be informed of any potential reform proposals. Without true public involvement and legislative oversight, the state executive branches will continue to cut Medicaid in a unilateral manner with limited checks on their authority, making access to healthcare even more difficult for the nation's most vulnerable citizens to obtain.

³ Robin Rudowitz and Andy Schneider, Kaiser Commission on Medicaid and the Uninsured, "The Nuts and Bolts of Making Medicaid Policy Changes: An Overview and a Look at the Deficit Reduction Act," August 2006.

⁴ Role of State Law in Limiting Medicaid Changes, National Health Law Program/National Assoc. of Community Health Centers.

State Medicaid Process & Oversight Legislation-A Model from Missouri

Missouri state law requires that the legislature approve changes to the state Medicaid plan made by both Section 1115 waivers and State Plan Amendments (SPAs). The following language can serve as a model for developing legislative oversight in your state.

V.A.M.S. 208.507

Application to receive federal waivers--promulgation of rules

The division of family services shall make such application as necessary to receive federal waiver(s) and shall promulgate rules and regulations necessary to implement the provisions of sections 208.500 to 208.507. No rule or portion of a rule promulgated under the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024, RSMo.

V.A.M.S. 536.024

Submission of rules to joint committee on administrative rules required--committee suspension of rules, grounds, reports to legislature, effect--legislative suspension or revocation of rules, recommendations by committee, hearings--notice of suspension

1. When the general assembly authorizes any state agency to adopt administrative rules or regulations, the granting of such rulemaking authority and the validity of such rules and regulations is contingent upon the agency complying with the provisions of this section in promulgating such rules after June 3, 1994.
2. Upon filing any proposed rule with the secretary of state, the filing agency shall concurrently submit such proposed rule to the joint committee on administrative rules, which may hold hearings upon any proposed rule or portion thereof at any time.
3. A final order of rulemaking shall not be filed with the secretary of state until thirty days after such final order of rulemaking has been received by the committee. The committee may hold one or more hearings upon such final order of rulemaking during the thirty-day period.
4. The committee may file with the secretary of state any comments or recommendations that the committee has concerning a proposed or final order of rulemaking. Such comments shall be published in the Missouri Register.
5. The committee may refer comments or recommendations concerning such rule to the appropriations and budget committees of the house of representatives and the appropriations committee of the senate for further action.
6. The provisions of this section shall not apply to rules adopted by the labor and industrial relations commission.

V.A.M.S. 536.028

Delegation of authority--effectiveness of order--notice of proposed rulemaking--committee recommendations--adoption of concurrent resolutions-- severability of provisions-- revocation of rules

1. Notwithstanding provisions of this chapter to the contrary, the delegation of authority to any state agency to propose to the general assembly rules as provided under this section is contingent upon the agency complying with the provisions of this chapter and this delegation of legislative power to the agency to propose a final order of rulemaking containing a rule or portion thereof that has the effect of substantive law, other than a rule relating to the agency's organization and internal management, is contingent and dependent upon the power of the general assembly to review such proposed order of rulemaking, to delay the effective date of such proposed order of rulemaking until the expiration of at least thirty legislative days of a regular session after such order is filed with the general assembly and the secretary of state, and to disapprove and annul any rule or portion thereof contained in such order of rulemaking.

2. No rule or portion of a rule that has the effect of substantive law shall become effective until the final order of rulemaking has been reviewed by the general assembly in accordance with the procedures provided pursuant to this chapter. Any agency's authority to propose an order of rulemaking is dependent upon the power of the general assembly to disapprove and annul any such proposed rule or portion thereof.

3. In order for the general assembly to have an effective opportunity to be advised of rules proposed by any state agency, an agency shall propose a rule or order of rulemaking by complying with the procedures provided in this chapter, except that the notice of proposed rulemaking shall first be filed with the general assembly by providing a copy thereof to the joint committee on administrative rules, which may hold hearings upon any proposed rule, order of rulemaking or portion thereof at any time. The agency shall cooperate with the joint committee on administrative rules by providing any witnesses, documents or information within the control of the agency as may be requested.

4. Such proposed order of rulemaking shall not become effective prior to the expiration of thirty legislative days of a regular session after such order is filed with the secretary of state and the joint committee on administrative rules.

5. The committee may, by majority vote of its members, recommend that the general assembly disapprove and annul any rule or portion thereof contained in an order of rulemaking after hearings thereon and upon a finding that such rule or portion thereof should be disapproved and annulled. Grounds upon which the committee may recommend such action include, but are not limited to:

(1) Such rule is substantive in nature in that it creates rights or liabilities or provides for sanctions as to any person, corporation or other legal entity; and

(2) Such rule or portion thereof is not in the public interest or is not authorized by the general assembly for one or more of the following grounds:

- (a) An absence of statutory authority for the proposed rule;
 - (b) The proposed rule is in conflict with state law;
 - (c) Such proposed rule is likely to substantially endanger the public health, safety or welfare;
 - (d) The rule exceeds the purpose, or is more restrictive than is necessary to carry out the purpose, of the statute granting rulemaking authority;
 - (e) A substantial change in circumstance has occurred since enactment of the law upon which the proposed rule is based as to result in a conflict between the purpose of the law and the proposed rule, or as to create a substantial danger to public health and welfare; or
 - (f) The proposed rule is so arbitrary and capricious as to create such substantial inequity as to be unreasonably burdensome on persons affected.
6. Any recommendation or report issued by the committee pursuant to subsection 5 of this section shall be admissible as evidence in any judicial proceeding and entitled to judicial notice without further proof.
7. The general assembly may adopt a concurrent resolution in accordance with the provisions of article IV, section 8 of the Missouri Constitution to disapprove and annul any rule or portion thereof.
8. Any rule or portion thereof not disapproved within thirty legislative days of a regular session pursuant to subsection 7 of this section shall be deemed approved by the general assembly and the secretary of state may publish such final order of rulemaking as soon as practicable upon the expiration of thirty legislative days of a regular session after the final order of rulemaking was filed with the secretary of state and the joint committee on administrative rules.
9. Upon adoption of such concurrent resolution as provided in subsection 7 of this section, the secretary of state shall not publish the order of rulemaking until the expiration of time necessary for such resolution to be signed by the governor, or vetoed and subsequently acted upon by the general assembly pursuant to article III, section 32 of the Missouri Constitution. If such concurrent resolution is adopted and signed by the governor or otherwise reconsidered pursuant to article III, section 32, the secretary of state shall publish in the Missouri Register, as soon as practicable, the order of rulemaking along with notice of the proposed rules or portions thereof which are disapproved and annulled by the general assembly.
10. Notwithstanding the provisions of section 1.140, RSMo, the provisions of this section, section 536.021 and section 536.025 are nonseverable and the delegation of legislative authority to an agency to propose orders of rulemaking is essentially dependent upon the powers vested with the general assembly as provided herein. If any of the powers vested with the general assembly or the joint committee on administrative rules to review, to hold in abeyance the rule pending action by the general assembly, to delay the effective date or to disapprove and annul a

rule or portion of a rule contained in an order of rulemaking, are held unconstitutional or invalid, the purported grant of rulemaking authority and any rule so proposed and contained in the order of rulemaking shall be revoked and shall be null, void and unenforceable.

11. Nothing in this section shall prevent the general assembly from adopting by concurrent resolution or bill within thirty legislative days of a regular session the rules or portions thereof, or as the same may be amended or annulled, as contained in a proposed order of rulemaking. In that event, the proposed order of rulemaking shall have been superseded and the order and any rule proposed therein shall be null, void and unenforceable. The secretary of state shall not publish a proposed order of rulemaking acted upon as described herein.

12. Upon adoption of any rule now or hereafter in effect, such rule or portion thereof may be revoked by the general assembly either by bill or by concurrent resolution pursuant to article IV, section 8 of the constitution on recommendation of the joint committee on administrative rules. The secretary of state shall publish in the Missouri Register, as soon as practicable, notice of the revocation.

13. This section shall become effective only upon the expiration of twenty calendar days following the:

- (1) Failure of the executive to sign executive order number 97-97; or
- (2) Modification, amendment or rescission of executive order number 97-97; or
- (3) An agency's failure to hold the rule in abeyance as required by executive order number 97-97; or
- (4) Declaration by a court with jurisdiction that section 536.024 or any portion of executive order number 97-97 is unconstitutional or invalid for any reason.

Notwithstanding the provisions of this subsection to the contrary, no modification, amendment or rescission of executive order number 97-97 or failure to hold a rule in abeyance shall make this section effective if the modification, amendment or rescission of the executive order or failure to hold the rule in abeyance is approved by the general assembly by concurrent resolution.

Lobbying 101: Communicating Effectively with Your Government

Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that can. -- Margaret Mead

“Lobbying” is simply persuading legislators or other government officials to act in favor of a specific cause. It is one of the most important things an advocate can do.

Basic Ways to Lobby: Letters, Calls & Meetings

Letters

Personal letters are extremely effective because they show legislators that the author is knowledgeable, interested, and committed to the matter at hand. Sending a personal letter also alerts the legislator to the fact that the author is politically active. Legislators keep close track of how their mail is running on particular issues, and personal letters are given great weight.

The letter should be short and to the point. Try to address only one issue in each letter. Start the letter by stating what it is you want the legislator to do, e.g. "Please vote in favor of House Bill 000." Explain the reason(s) that you care about this issue, including ways in which the issue touches you personally. Where relevant, emphasize the specific impact of the issue within the legislator's district.

Be sure to find out what happened on the issue you wrote about and let your legislators know that you are following their action on this issue. It is great to write a "thank you" note if they voted the way you wanted on an issue. Send a note of regret if they voted against your wishes.

If you can, faxing your letter is probably the most effective delivery method. E-mails seem less personal and, therefore, are less persuasive. Regular mail is slow due to enhanced security measures.

Telephone Calls

Call your representatives. Federal representatives can be reached at their offices in Washington, DC or at their state offices, or just call the U.S. Capitol switchboard at 1-202-224-3121 and ask for the Member by name. Explain that you are a constituent and ask to speak to the staffer who follows your issue. Make the call short, polite and to the point.

Follow-up on the call. Be sure to call back and thank the legislator for their support or very politely express regret at their vote.

Meetings

Public Meetings-- Officials often host “town hall meetings” open to the public where you can ask questions about specific issues. Call your member's district office (check the blue section of the telephone book) to see if any are scheduled.

Private Meetings—If you arrange a private meeting, it is useful to remember that you are there to exchange ideas. It is sometimes just as important to know why a legislator opposes your position as it is to know that the legislator supports your position.

Leave literature for the legislator summarizing your points. This will serve as a reminder of your visit and the issue.

Follow up the visit with a thank you note and perhaps more information on your issue. If the legislator asked for certain information be sure you get back to the legislator with that information. Remember that the main objective of your contact is to establish an ongoing relationship with your legislator and establish yourself (and any organization you represent) as a reliable source of information.

The Best Times to Lobby

There are special times in the legislative process when letters, calls and meetings can be especially productive:

- When a bill is introduced and assigned to a committee, you can contact your legislators to request that they become official supporters of the bill by “cosponsoring” the bill. Obviously, the more cosponsors a bill has, the more likely it is to gain support and move through the legislative process.
- If the bill is bottled up in committee and appears unlikely to ever emerge, you might contact your Members of Congress and urge them to get the bill moving.
- In the Senate, a minority of Senators can stop passage of a bill by launching a “filibuster,” essentially an endless debate. Many campaign finance efforts over the years have fallen victim to Senate filibusters. The votes of 60 Senators are needed to end a filibuster and allow action on a bill. You might contact your Senators and urge them to fight these tactics used to block action on important legislation.
- When legislation is about to come up on the floor of the House or Senate, you could contact your legislators and urge support for the position you advocate.

You can learn the federal status of a bill by going to <http://thomas.loc.gov/> and searching the bill by name or number.

General Lobbying Advice:

- **Know Your Legislator** Be sure to do some basic research in order to help you understand how a legislator might approach an issue. This should include: an examination of his/her record on related legislation; any prior favorable commitment to your cause, party, or position; and what kind of influence the legislator will have over the issue, e.g. will the issue come before a Committee your legislator sits on?
- **Know Your Issue** Know the status of the legislation and be sure to know the bill's name and number. Buttress your arguments with the most salient and persuasive facts available. Anticipate arguments against your position, and be prepared to respond to these arguments.
- **Be accurate.** To build a working relationship and get action, you need to be a credible source of information. Never bluff. If you don't know something, just say so. Tell them you will find out and get back to them.
- **Make It Personal (and Local)** Establish your own credentials or expertise on the subject of legislation under consideration. Make a personal connection to the issue you are discussing. Do not be afraid to speak from personal experience. Whenever possible, speak locally. Connect the position you support to the people the official represents.
- **Be brief.** Members of Congress and their staffs are incredibly busy and so are you. Most members of Congress represent over 600,000 people. They appreciate it when you get to the point and respect their time. Because your meeting or call might be interrupted, get to your request in the first few minutes.
- **Have an Objective and an "Ask"** Have a clear objective for any call, letter or meeting. This should include a very specific request: "Vote for Bill No. 103 to provide health care to 1000 of your constituents" not "Support health care for all Americans."
- **Be specific.** In your communications with Members of Congress, make a point to mention the bill by number, give reasons why you support the bill, and let them know that you are a constituent.
- **Be courteous.** If you meet with the legislator's staff, treat this meeting as though it is with the legislator. The legislator depends on this staff person's advice, and this staff person serves as your gateway to the legislator. Treat him or her with respect. Try to persuade, but never argue with him or her.
- **Be persistent.** If you find that the staff people you need to speak with are out of the office, leave a message for them with your name and number. If they don't return your call within two to three days, then call again. Keep track of your calls, but remember that they are very busy.

Lobbying Law Basics

It is legal for both individuals and organizations to lobby.

Even organizations recognized by the Internal Revenue Service as non-profit 501(c)(3) organizations can legally lobby Congress on issues they care about. There are limitations on the expenditure of organizational funds, but it is not illegal as many in the international development community have believed. In fact, lobbying by non-profit organizations is encouraged by a 1976 tax law and its accompanying regulations.

It is important to understand the limitations so the organizations to which we belong are able to maximize their ability to influence legislation without jeopardizing their legal status. This section offers only basic information, but you are encouraged to learn more so that you and your organizations take advantage of your rights. *

While there are limitations on how much of an organization's budget can be spent on lobbying, there is NO limitation on individual citizens and constituents. It is a First Amendment right and one of the privileges and responsibilities of living in a democracy to be able to exercise the right to meet with politicians, tell them how we want them to vote and then let them know on election day if we thought they did a good job.

What can non-profit organizations do legally?

It is important to remember that any non-profit organization is permitted to lobby and that it will never jeopardize its 501(c)(3) tax status as long as it abides by the Internal Revenue Service regulations. Regarding lobbying, there are two facts to understand:

1. Lobbying is defined by the IRS as expenditure of an organization's resources to promote particular legislation. Direct lobbying is when money is spent for communication to a legislator or government employee who may participate in the formation of the legislation and both (1) refers to the legislation and (2) expresses a view on the legislation. Grass Roots lobbying is an attempt to influence specific legislation by encouraging the public to contact legislators about that legislation. Such grass roots lobbying (1) refers to specific legislation, (2) reflects a view about the legislation, and (3) encourages people to communicate with Members of Congress about that legislation. If the group doesn't spend funds for these purposes, according to the IRS, it has not lobbied. IRS lobbying laws do not limit the education of legislators. Organizations can inform their members about the legislative process and how citizens can influence the process. Lobbying simply refers to the allocation of an organization's funds for the purpose of influencing specific legislation.

2. A 501(c)(3) organization can spend an "insubstantial" amount (usually interpreted as 5%) of its budget on lobbying, or an organization can opt to spend up to 20% by filing IRS form 5768 and electing to come under the provisions of a 1976 law. Education and research expenditures are not reported as lobbying.

In addition to educating and lobbying Congress, a non-profit organization can educate its individual members, contributors and supporters about the importance of educating and lobbying Congress. Congress is usually more impressed by an informed district constituency (voters) who regularly visit their district offices than they are by visits paid by lobbyists in Washington, D.C. They are impressed if they have both visits from paid lobbyists in D.C. where they are their legislative assistants are kept well informed AND by constituents back home who demonstrate that citizens care about the developing world.

What can one person do?

As a constituent, you can call, write and visit your Members of Congress. As an individual YOU CAN lobby for or against specific legislation, urge passage or defeat of a bill and try to directly influence the laws that govern our lives. Whenever you are in Washington, D.C., you can visit congressional offices, but Congresspeople are regularly in their district offices, and you can visit with them there. The key to being an effective advocate is to develop an on-going relationship, provide reliable information and understand the basics of the legislative process. (Refer to the section on the decision making process for a summary.)

As a citizen advocate, you can promote specific legislation while informing elected officials about health care issues. You can bring others with you to represent a diverse group of constituents and demonstrate the breadth of support for the expansion of the Medicaid system. If you have worked on programs that benefit from developmental assistance, you may know more than the legislator or his/her legislative assistant, and you can be an asset by providing this information. This information can be given by mail, visits, fax or phone. If you are involved in one or more organizations, ask the organizations to send their materials to your member of Congress and his/her legislative assistant.

As an effective advocate, you should use your time with your legislators wisely and efficiently. They are busy people, and you should come prepared. It is important for you to know his/her party affiliation, past voting record (if any), committee assignments and the characteristics of the district. If possible, work with representatives of other organizations to determine how many groups in the district support Medicaid and how many people that represents. It is also important to develop a relationship with the Legislative Assistant who works on the issues. S/he may be better informed on specific issues and often turns to effective and reliable advocates for information.

* For more information about IRS regulations, refer to *Being a Player: A Guide to the IRS Lobbying Regulations for Advocacy Charities*, prepared in 1991 for the Advocacy Forum, a project of the Alliance for Justice, 1601 Connecticut Ave., N.W., Washington, D.C. 20009. Also refer to *The NonProfit Lobbying Guide*; Jossey-Bass Publishers, 1991.

Tips for Effectively Using the Media

You can engage the media in Medicaid through letters to the editor, talking to reporters, issuing press releases, or by organizing press events to generate media coverage. This will allow your story to reach a wider audience and educate the broader public about Medicaid in your state.

Whatever media outreach option you choose, you will need to convey a message.

TIP 1: Hone your message. Keep it as straightforward as possible. Remember that your initial goal is not to thoroughly educate reporters about the program. Once you capture their attention, you can give more detail.

Messages are the overarching points that your organization wants to convey about an issue.

- Messages should support your main goals.
- Messages take time to create. You shouldn't rush the process.
- Messages should not change frequently. To have impact, they must be repeated over and over again. Stay on point.
- Less is more. Within a single campaign, don't have more than 3 or 4 messages. More is too confusing and won't get heard.
- Keep it short. Messages should be conveyed in a sentence or two. If it takes a paragraph, keep working.
- Make it understandable. Use plain language and avoid specialized vocabulary or acronyms.
- Make it memorable. Use sound bites, statistics and anecdotes. Real people stories are ideal. Have people available who receive Medicaid benefits prepared to talk to the press about why the program is important to them.

TIP 2: Once you establish your message, reach out to reporters and writers at local newspapers to discuss Medicaid and its importance to women and families.

Pitch Call

Purpose is to propose a story idea, an interview or coverage of an event.

- Be succinct and persuasive – you have one or two minutes.
- Make your calls in the morning.
 - Print media deadlines can be as early as 4 pm.
 - For television, pitch two days ahead when possible. Decisions to send crews made night before a story appears on air.
- Begin with reporters you know.
- Offer a hook – even if you spark the reporters' interest, they may still need to sell it to their editors.
- Find ways to localize.
- Follow up with written information, if needed.
- Use pitch calls to build relationships:
 - Get to know journalists who cover your field.

- Call them with response to breaking news and with good, quotable quotes.
- Suggest interview “experts” or “real people.”
- Suggest getting together to discuss additional story ideas.

TIP 3: Use media advisories to announce an event, and use press releases to announce or respond to breaking news

Press Release

Announces or Reacts to Breaking News and is Written Like a News Story

- **Headline:** grab reporters’ attention.
- **Lead sentence:** summarize what’s most newsworthy.
- **Next:** facts and supporting quotes.
- **End of statement:** paragraph mission statement from organization.
- If reporters need substantial time to prepare story, send an embargoed release ahead of the release date.
- If e-mailing, subject line must grab the reporter – and never send attachments.

Media Advisory

Alerts Reporters to an Upcoming News Event.

- **Keep it short (one-page)**
 - List event and its participants, date and location.
 - Briefly identify the purpose of the event.
- **Offer a compelling preview**
 - Strong headline and lead sentence to peak reporters’ interest.
 - Don’t reveal your news but provide a reason for them to attend.
- Fax or e-mail to reporters who cover the issue, editors, news directors, bureau chiefs, TV/radio producers, and daybooks.
- Follow up with a phone call (pitch call).

TIP 4: Once you have successfully garnered media attention, you will do over the telephone or in person interviews with reporters. You can prepare for the interview by knowing all sides of the issue and thinking in advance about what kinds of questions the reporter will ask

Preparing for a Media Interview

- Remember the audience ... readers, listeners, viewers, not the reporter.
- What questions will the reporter likely ask?
- Have your message points and soundbites ready.
- Know your opponents’ viewpoints and have counterpoints ready.
- Don’t make things up and never lie.

The Interview

- In the presence of the media, you are always “on.” Be careful what you say –reporters have a job to do.
- Set ground rules – Don’t say anything you wouldn’t want to see in the paper.
 - On the Record
 - Off the Record

- On Background
- Stay on message!
- Don't use jargon or acronyms.
- It's okay to say you'll get back to them with additional information.
- When reporters ask incendiary questions or something you may not be comfortable asking, use these "off message," questions to bridge your point. E.g.:
 - The best way to answer that is to look at the broader issue...
 - What's really at issue here...
 - That's a good question. But first let me go back to an earlier point...
- Be concise. For TV, your interview will be edited to a 10-20 second clip.

TIP 5: Letters to the editor and op-eds provide outlets to concisely discuss your organization's view and control the message.

Letter to the Editor -- *A Short Rebuttal to an Article or Commentary, Usually 150-200 Words.* If you get a story about Medicaid placed in the newspaper, or if a newspaper runs a story on Medicaid, ask the families or individuals you work with to follow up with letters to the editor about how Medicaid has helped them.

- Keep it short and be factual but not dull.
- Timing is everything. Getting a letter the same day will increase your chances of publication. If a whole week has gone by, don't bother.
- Send it by e-mail in the body of the text, not as an attachment.

Op-Ed

A Column or Guest Essay, Typically 500-700 Words in Length.

- Should be timely, lively, forceful, and well written.
 - Unusual or provocative opinion on a current issue, a call-to-arms, or an expert take on an issue by a well-known name.
 - Not event announcements or generic ideas; want readers to say, "Wow, did you see that op-ed today?"
- Determine your goal and audience, then determine the news outlet that can best deliver your op-ed to your target audience.
- Figure out what you want to say and who can say it.
- Make your points compelling – first sentence should grab the readers' attention and everything that follows should keep it.

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The National Women's Law Center is a non-profit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families including economic security, education, employment and health, with special attention given to the concerns of low-income women. For more information on the Center visit: www.nwlc.org.

SAMPLE EDIT MEMO

EDIT MEMORANDUM

To: Editorial Page Editors, Writers and Columnists
From: Judy Waxman, Vice-President, National Women's Law Center
Date: 14 June 2005
Re: **NGA Medicaid Reform Agenda: Putting Beneficiaries at Risk**

The National Governor's Association released an interim Medicaid policy in June that includes recommendations that are likely to cause great harm to Medicaid beneficiaries. The policy proposes benefit modifications and cost-sharing, which means Medicaid coverage would become less comprehensive and many of its current recipients would be unable to afford participation in the program.

The NGA will present this proposal Wednesday to Congress during a hearing before the Senate Finance Committee and a hearing before the House Energy and Commerce Committee.

The public should be aware of the sweeping Medicaid changes being proposed by the NGA and Congress. Roughly 53 million low-income and working Americans rely on Medicaid for health care. We urge you to examine the NGA's proposed changes to Medicaid as well as Congress's planned changes and write about the impact of these proposals on Americans.

Although the NGA's interim policy lacks detail, the NGA's cost-sharing proposals appear wide-reaching. It could mean that children and pregnant women, who are currently exempt from cost-sharing, will be forced to pay co-payments. These populations are especially well-served by preventive and proactive care, but the imposition of co-payments will limit their access to services. Study after study shows that patients cannot afford the increased co-payments and therefore do not seek needed care; this is the primary reason co-payments "save money." Saving money in this way threatens the health of low-income Americans and will cost more in the long term.

Moreover, the NGA plan also includes a recommendation which would severely limit legal remedies for program beneficiaries by time-limiting court consent decrees. This change would put a tremendous burden on advocates and make it nearly impossible for them to ensure that beneficiaries receive the care mandated by federal law.

To interview Judy Waxman about these changes and their impact on low-income and working Americans and women, please call 202-588-5180 and ask for Ranit Schmelzer or Jenice Robinson.

To view the NGA's proposal, visit:

<http://www.nga.org/nga/legislativeUpdate/policyPositionDetailPrint/1,1390,8460,00.html>

To view the National Women's Law Center's fact sheet on cost sharing visit:

<http://www.nwlc.org/pdf/6-2005MedicaidCost-Sharing.pdf>

To view the National Women's Law Center's sign on letter on consent decrees visit:

<http://www.nwlc.org/pdf/4-26-05ConsentDecreeSign-On.pdf>

To view the National Women's Law Center's fact sheet on parents, visit:

<http://www.nwlc.org/pdf/6-2005MedicaidParents.pdf>

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The National Women's Law Center is a non-profit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families including economic security, education, employment and health, with special attention given to the concerns of low-income women. For more information on the Center visit: www.nwlc.org.

SAMPLE OP-ED

Medicaid, An Essential Lifeline

By Marcia D. Greenberger and Judy Waxman

It's no secret that low-income, working Americans are being forced to make the biggest sacrifices as the federal and state governments look for ways to cut spending while preserving tax cuts for the wealthy. Programs that improve quality of life for the poor have all too often been the first on the chopping block, and this year it is especially true for Medicaid, the federal and state program that provides health insurance for more than 54 million poor Americans. The program's enrollment has grown by one-third since 2000, thereby increasing Medicaid's annual costs and making the program an easy scapegoat for lawmakers who want to rein in spending.

Too many politicians would rather blame the program than address the larger issues of fewer good jobs that provide health insurance and soaring health care cost. The problem with this singular focus on slashing the program's costs is that it ignores harsh realities about health care in this country and the underlying reasons why millions of Americans now have to look to Medicaid for health coverage. The increase in Medicaid spending reflects how dramatically overall health care costs have risen and how the standard of living for low-income, working Americans has eroded in recent years. Rising health care costs mean that fewer employers are sponsoring coverage and more Americans are without insurance.

These harsh truths about the expanding need for Medicaid should be a significant part of the Medicaid reform debate, but instead policymakers would rather focus on curbing the program's growth. Toward this end, Congress agreed earlier this year to cut \$10 to \$15 billion from the program over the next five years and to establish a Medicaid commission to make recommendations on how to allocate those cuts and change the program overall.

In the meantime, the National Governor's Association has proposed to save money by allowing states to impose cost sharing on previously exempt populations such as hospice patients, pregnant women and children under 18. Cost sharing means beneficiaries would pay co-payments for medical visits or monthly premiums to maintain health coverage.

Unfortunately, cost-sharing would not resolve the problems of rising health care costs. Studies and precedent show that imposing cost sharing saves money in the short run by limiting access to health care, but it doesn't save money in the long run. Those who can't afford co-payments or premiums avoid or delay essential medical care and often drop out of publicly funded health insurance programs altogether.

One example of how cost sharing doesn't work is Oregon. When the state imposed cost sharing on Medicaid beneficiaries in 2003, it prevented half of those previously eligible from

maintaining coverage. Sixty percent of those who left the state Medicaid program later reported an unmet medical need.

On its surface, Medicaid cost sharing may sound reasonable considering most Americans with private health insurance experience co-payments or premiums. But in reality, people who can afford to pay premiums aren't the ones who are eligible for Medicaid. Although income requirements vary by state and population, Medicaid beneficiaries are often destitute. For example, the median eligibility level for a working mother with two children is \$426 per month. On this sort of budget, it would be impossible for a family to pay monthly premiums or co-payments.

By and large, all Americans are feeling the pinch from rising health care costs. Perhaps this is why so many Americans (74 percent in a recent survey by Kaiser Family Foundation) consider Medicaid to be a very important government program.

By cutting Medicaid, we will exacerbate existing problems by increasing the ranks of the uninsured and causing all Americans to pay more for health care to cover the expanded numbers of uninsured. Needy Americans will have to forego care until serious and expensive emergencies arise. With no other way to absorb the costs of this unpaid care, hospitals will raise their prices. In response, insurers will further raise their premiums. And so on.

Instead of proposing short-term remedies that will increase the number of uninsured and cost the public more in the long-term, policymakers should explore how to make overall health care more affordable and keep programs intact that make health care accessible.

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SAMPLE LTE

To the Editor:

Gardiner Harris's June 19 article (Gee, Fixing Welfare Seemed Like a Snap) repeated the National Governor's Association erroneous claim that Medicaid accounts for 22 percent of state budgets, and that states pay more for Medicaid than elementary and secondary education. In fact, state spending on Medicaid accounts for an average 12.7 percent of state budgets, which is far below K-12 and higher education costs, according to the Congressional Research Service.

The governors' singular focus on Medicaid as a percentage of state budgets ignores larger issues: states are paying more for Medicaid today than five years ago because overall health care costs have risen and program enrollment has increased. Slashing Medicaid spending is a quick fix for curbing public expenditures but will not solve these underlying issues.

By dealing with budget woes through scaling down public health insurance programs, we are merely borrowing time. In the end, the public will pay more as the poor forego routine and needed medical care and require more expensive care when they become even sicker. And still, we will not have addressed the growing ranks of uninsured Americans.

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