



## REPRODUCTIVE RIGHTS & HEALTH

# THE STEALTH ATTACK ON WOMEN'S HEALTH: WHAT CAPS ON MEDICAID FUNDING WOULD MEAN FOR WOMEN

Recent proposals to restructure the Medicaid program as a per capita caps program threaten health care coverage and benefits for tens of millions of Americans—and would hit women especially hard.

### MEDICAID IS VITAL TO WOMEN'S HEALTH AT ALL STAGES OF THEIR LIVES.

- Medicaid provides health care coverage to about 17 percent of women aged 18 to 64, and is particularly important for the poorest and sickest women<sup>1</sup>
- About 70 percent of adult Medicaid beneficiaries are women.<sup>2</sup>
- Medicaid finances nearly half of all births in the United States and accounts for 75 percent of all publicly funded family planning services.<sup>3</sup>
- Medicaid provides assistance to low- and moderate-income seniors for Medicare premiums, deductibles, and co-payments, and covers services that Medicare does not, such as long-term care. More than two-thirds of seniors who receive coverage through Medicaid are women.<sup>4</sup>
- Medicaid provides about half of all long-term care spending.<sup>5</sup> Coverage of long-term care expenses is especially important to women, because they are more likely to live longer than men, experience disability, and be poor. About two out of three nursing home residents and people receiving home health care services are women.<sup>6</sup>

### PROPOSALS TO CHANGE MEDICAID TO A PER CAPITA CAPS SYSTEM WOULD END MEDICAID AS WE KNOW IT.

***Medicaid works because federal funding automatically responds to changing needs.***

Currently, everyone who is eligible for Medicaid is guaranteed coverage, and the federal government and states share the costs. The federal government provides 50 to 77 percent of what each state spends on Medicaid, with states with lower per capita income receiving a higher percentage of their costs from the federal government.<sup>7</sup> The federal government provides a higher reimbursement rate for some populations, including low-income adults newly eligible under the Affordable Care Act's Medicaid expansion, and for some services, including family planning and breast and cervical cancer treatment.<sup>8</sup> If the need for Medicaid increases—for example, to cover newly eligible people during a recession, meet new health challenges from the opioid epidemic or Zika virus, or provide effective but expensive new treatments—federal funding automatically increases and is automatically directed to the states experiencing the need.

State Medicaid programs must meet basic federal standards to receive federal funding, but they also already have considerable flexibility. For example, states must cover certain categories of people, including poor children, extremely destitute parents, low-income pregnant women, the low-income elderly, and impoverished people with disabilities.<sup>9</sup> Programs must cover a wide range of critical health care services, including early and periodic screening, diagnostic, and treatment (EPSDT) services for children and family planning.<sup>10</sup> States have the option to cover certain additional groups of people (in addition to the groups eligible for the ACA Medicaid expansion) and to provide certain additional services and receive federal matching funds. States also have flexibility to develop new ways of delivering services that can improve the quality of care at lower cost.<sup>11</sup>

### ***A per capita cap system would mean the end of this responsiveness.***

Proposals to change Medicaid to a per capita cap system would set a limit on spending for each beneficiary. This would end Medicaid's current open-ended funding that responds to need.



***A per capita cap system is similar in many respects to a block grant.***

Like a block grant, the per capita cap limits and cuts federal funding. Both shift to states the risk of increases in Medicaid costs, which would force states to cut Medicaid coverage and benefits—and possibly other services as well. One difference is that unlike a block grant, funding under a per capita cap would respond to a change in the number of beneficiaries covered. However, as explained further below, this does not mean that states would be able to maintain the numbers of people covered, much less maintain benefits.

**CHANGING MEDICAID TO A PER CAPITA CAP PROGRAM WOULD MEAN CUTS IN COVERAGE AND BENEFITS FOR WOMEN AND THEIR FAMILIES.**

***The “flexibility” with capped funding means giving states the ability to do less with less.***

Proponents of capped funding proposals claim that additional flexibility will enable states to manage with less. In reality, it will mean giving states the ability to cover fewer people and provide fewer benefits.

The federal government could give states “flexibility” to limit the number of people covered. This could be done directly, by eliminating eligibility for some groups or by establishing enrollment caps and wait lists. It could be done indirectly, by imposing work requirements or lockout periods. The federal government could also give states new “flexibility” to reduce benefits. This could be done directly, by eliminating mandatory benefits such as family planning and diagnostic and treatment services for young children and limiting utilization. It could be done indirectly, by raising the amount that low-income families must pay for such services, through premiums, deductibles, co-payments, and spend-down rules for long-term care services.<sup>12</sup>

***Per capita caps will not prevent cuts in coverage.***

A per capita cap provides some additional reimbursement as the number of enrollees increases, unlike a block grant. However, per capita reimbursements that do not adequately compensate for the cost of providing care to beneficiaries and do not provide an incentive to maintain enrollments, especially of individuals most in need of health care services. More beneficiaries with inadequate federal reimbursements mean higher costs for the state.

The dangers of per capita caps are not hypothetical, an analysis published in the *New England Journal of Medicine* found.<sup>13</sup> Before Medicaid was enacted in 1965, the federal government financed health care for welfare recipients using a reimbursement method similar to that recently proposed in the Affordable Care Act repeal bill, the American Health Care Act. Reimbursements were subject to per capita caps. Rates

were based on average costs, differed for different groups of beneficiaries (elderly and blind or disabled, and single-parent families), and reimbursement rates varied inversely with state income. “Per capita caps gave states strong incentives to minimize per-enrollee medical costs”—and they responded with tight restrictions on eligibility, coverage, and utilization.<sup>14</sup>

Eleven states provided no care for children; roughly 20 states declined to cover hospital services, doctor visits, or drugs for some groups of recipients. Among states that did reimburse for such care, 12 (of 39) restricted hospital utilization, 17 (of 31) restricted doctor visits, and 8 (of 32) limited prescription-drug utilization. Welfare recipients in Kentucky could receive [Medical Vendor Payments] only for a hospital visit for “life-endangering conditions,” and recipients in Montana could go to a hospital or doctor only if their vision was in danger.<sup>15</sup>

The authors conclude, “as in the 1950s, discouraging Medicaid recipients from receiving costly care or keeping the highest-cost patients out of the program would be the clearest ways to limit state outlays.”<sup>16</sup>

***Per capita caps will put women’s health and economic security at risk.***

Because per capita caps are likely to result in fewer people being covered and for those who are covered, fewer services being covered and at higher cost, the end result is that low-income individuals will lose insurance coverage and access to critical services. This puts women’s health and lives at risk. Uninsured low-income women are more likely to go without care because of cost, are less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. A growing body of research has demonstrated how important Medicaid coverage is to enrollees’ access to care, overall health and mortality rates.<sup>17</sup> Among all sources of coverage, Medicaid disproportionately covers the poorest and sickest population of women.<sup>18</sup>

At the same time, Medicaid has played a critically important role in advancing women’s economic security.<sup>19</sup> It keeps women and their families from medical debt and bankruptcy. By providing health coverage to women and their families that is not tied to employment, Medicaid allows women to seek positions that may offer higher wages or better opportunities, and it also has improved the economic security of future generations. Medicaid’s coverage of birth control allows women to determine whether and when to start a family, expanding their educational and career opportunities. And Medicaid payments to health care providers directly support women’s jobs. A per capita caps program would jeopardize these gains, putting the financial wellbeing of women and families on the line.

**DEEP CUTS IN FEDERAL MEDICAID FUNDING WILL**



## SQUEEZE STATE BUDGETS AND JEOPARDIZE OTHER SERVICES FOR WOMEN AND THEIR FAMILIES.

Medicaid accounted for more than half of all federal funds for states in FY 2017.<sup>20</sup> Thus, deep cuts in Medicaid funding will create large holes in state budgets. In addition to cutting their Medicaid programs, states may try to fill the budget gaps by cutting education, child care, and other services vital to women and their families.

- 1 KAISER FAMILY FOUND., *Women's Health Insurance Coverage* (Dec. 21, 2018), <https://kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/>.
- 2 KAISER FAMILY FOUND., *MEDICAID'S ROLE FOR WOMEN ACROSS THE LIFESPAN: CURRENT ISSUES AND THE IMPACT OF THE AFFORDABLE CARE ACT 1* (Dec. 2012), available at <http://kff.org/health-reform/fact-sheet/medicaids-role-for-women/>.
- 3 *Ibid.*
- 4 *Ibid.*
- 5 ERICA L. REAVES & MARYBETH MUSUMECI, KAISER FAMILY FOUND., *MEDICAID AND LONG-TERM SUPPORTS: A PRIMER 3* (Dec. 2015), available at <http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>.
- 6 *Supra* note 2, at 5.
- 7 ROBIN RUDOWITZ, KAISER FAMILY FOUND., *MEDICAID FINANCING: THE BASICS 2* (March 2019), available at [http://files.kff.org/attachment/Issue-Brief-Medicaid-Financing-The-Basics\\_](http://files.kff.org/attachment/Issue-Brief-Medicaid-Financing-The-Basics_).
- 8 *Ibid.*, 2.
- 9 NAT'L HEALTH POLICY FORUM, *THE BASICS: MEDICAID ELIGIBILITY AND BENEFITS 1-2* (Jan. 5, 2016), available at [https://www.nhpf.org/library/the-basics/Basics\\_Medicaid\\_01-05-16.pdf](https://www.nhpf.org/library/the-basics/Basics_Medicaid_01-05-16.pdf).
- 10 It is important to note that federal law restricts federal Medicaid coverage of abortion except if the pregnancy is the result of rape or incest, or if the woman's life is in danger. This is commonly known as the "Hyde Amendment." See, e.g., Continuing Appropriations Act, 2019, Pub L. No. 115-245 (2018).
- 11 Hannah Katch, CTR. ON BUDGET AND POLICY PRIORITIES, *States Are Using Flexibility to Create Successful, Innovative Medicaid Programs* (June 13, 2016), available at <http://www.cbpp.org/research/health/states-are-using-flexibility-to-create-successful-innovative-medicaid-programs>.
- 12 See, e.g., Edwin Park & Judith Solomon, CTR. ON BUDGET AND POLICY PRIORITIES, *Per Capita Caps or Block Grants Would Lead to Large and Growing Cuts in State Medicaid Programs* (June 22, 2016), available at <http://www.cbpp.org/research/health/per-capita-caps-or-block-grants-would-lead-to-large-and-growing-cuts-in-state>; Joan Alker, GEORGETOWN UNIV. HEALTH POLICY INST. FOR CHILDREN AND FAMILIES, *Why "State Flexibility" Won't Do the Trick to Implement Medicaid Cuts* (Mar. 9, 2017), <http://ccf.georgetown.edu/2017/03/09/why-state-flexibility-wont-do-the-trick-to-implement-medicaid-cuts/>; Julia Beliu, Giving black moms health insurance may save their babies' lives VOX (Apr 26, 2019, 8:20 AM), <https://www.vox.com/health-care/2019/4/26/18514196/black-infant-mortality-pregnancy-medicaid>.
- 13 Andrew J. Goodman-Bacon & Sayeh S. Nikpay, *Per Capita Caps in Medicaid — Lessons from the Past*, 376 NEW ENG. J. MED. 1005 (Mar. 2017).
- 14 *Ibid.*
- 15 *Ibid.*
- 16 *Ibid.*
- 17 Benjamin D. Somers et al., *Mortality and Access to Care Among Adults after State Medicaid Expansions*, 367 NEW ENG. J. MED. 1025 (July 2012); Julia Paradise & Rachel Garfield, *What is Medicaid's Impact on Access to Care, Health Outcomes and Quality of Care? Setting the Record Straight on the Evidence*, KAISER COMMISSION ON MEDICAID AND THE UNINSURED (Aug. 2013), available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/08/8467-what-is-medicaid-s-impact-on-access-to-care1.pdf>; Julia Beliu, Giving black moms health insurance may save their babies' lives VOX (Apr 26, 2019, 8:20 AM), <https://www.vox.com/health-care/2019/4/26/18514196/black-infant-mortality-pregnancy-medicaid>.
- 18 KAISER FAMILY FOUND., *Women's Health Insurance Coverage*, *supra* note 1.
- 19 See generally, NATIONAL WOMEN'S LAW CENTER, *Medicaid at 50: Celebrating Medicaid's Contributions to Women's Economic Security* (July 2015), available at [http://nwl.org/wp-content/uploads/2015/08/final\\_nwlc\\_medicaid50th\\_whitepaper\\_3.pdf](http://nwl.org/wp-content/uploads/2015/08/final_nwlc_medicaid50th_whitepaper_3.pdf).
- 20 ROBIN RUDOWITZ, *supra* note 7, at 8.

