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Political Tug-of-War Over Medicaid Could Have Major Implications for Reproductive Health Care

By Adam Sonfield

Fresh off Republican victories in the November 2010 elections, the newly Republican-controlled House of Representatives quickly established reducing the deficit without raising taxes—in other words, cutting government spending—as its top priority for 2011. As one of the largest and most rapidly growing components of the federal budget, Medicaid quickly emerged as one of the House's prime targets for cuts. The FY 2012 budget authored by Budget Committee Chairman Paul Ryan (R-WI) and approved by the House in April called for converting Medicaid from an open-ended entitlement program—the total price tag of which depends on the number of individuals legally eligible at any given time—into a fixed block grant to the states.[1] President Obama and the Democratic-controlled Senate rejected that idea, but substantial cuts to Medicaid were reportedly given serious consideration by policymakers from both parties during negotiations to increase the nation's debt ceiling this summer. Although ultimately spared in the initial round of cuts agreed to by Congress and President Obama, Medicaid remains a clear target, both in the second round of cuts that will come later this year and in the years ahead.

Meanwhile, governors and state legislators continue to struggle over budget shortfalls of historic proportions, as the lingering economic downturn has curtailed states' tax revenue while increasing their residents' demand for and legal entitlement to safety-net programs such as Medicaid. Opponents of the 2010 federal health reform legislation, the Patient Protection and Affordable Care Act (ACA), have asserted that the law's new requirements—particularly those around Medicaid—are limiting states' options for balancing their budgets. The Republican Governors Association has been especially vocal in calling for increased "flexibility" in states' ability to shape Medicaid and reduce the program's costs.

This renewed push to increase states' authority over Medicaid is in many ways antithetical to the ACA's changes to the program. Starting in 2014, the health reform law requires a nationwide floor of eligibility for Medicaid. This requirement will standardize what has up to now varied tremendously across the states and will greatly expand the program's role in providing insurance coverage for low-income Americans. The outcome of the continuing debate over the future of Medicaid, therefore, has considerable implications for the provision of reproductive health care in the United States.

Medicaid and Reproductive Health Today

Currently, whether someone qualifies for Medicaid coverage varies considerably across the states and depends on family income and other characteristics. Federal law requires states' income eligibility ceilings for children younger than 19 to be set at least at 100% of the federal poverty level, and nearly every state has chosen to enroll children at twice that level or higher through Medicaid or its sister program, the Children's Health Insurance Program (CHIP).[2] (The poverty level in 2011 was $10,890 for a single person or $18,530 for a family of three.[3]) Coverage for adult parents varies more dramatically, with the median income eligibility level at 64% of poverty and several states setting their level at 25% or below.[2] In all but a handful of

states, childless adults are typically excluded from Medicaid altogether; by federal law, most immigrants are excluded for their first five years of legal residence.

Medicaid enrollees have traditionally been guaranteed a broad package of sexual and reproductive health services. Notably, federal law requires states to cover pregnancy-related care (including prenatal care, labor and delivery, and 60 days of postpartum care) and family planning services and supplies; in both cases, states have latitude in how to define those service categories, but all cover a wide range of services, screenings and supplies.[4,5] Federal law also requires that these two sets of services be exempt from cost-sharing, although "nominal" out-of-pocket costs are typically allowed under Medicaid. Similarly, all states cover testing and treatment for the full range of STIs, including HIV, as well as pregnancy tests, cervical cancer screening and most other reproductive health services. The major exception is abortion: Federal law has for more than 30 years barred federal reimbursement for abortion except in the most extreme circumstances, although 17 states, accounting for just under half of U.S. women aged 15–44, use their own funds to pay for abortions for Medicaid enrollees.[6,7]

In addition, there are three types of Medicaid expansion programs that provide reproductive health services to people who do not otherwise qualify for Medicaid. First, all states are required to cover pregnancy-related care for women during pregnancy and for 60 days postpartum, with a minimum income ceiling of 133% of poverty; the large majority of states set that ceiling at or near 200%.[2] Second, the ACA gave states immediate authority to provide Medicaid coverage of family planning services and related care to women and men up to income levels equivalent to what the state has set for pregnancy-related care; 22 states operate such eligibility expansions, four of them under this new authority and another 18 as demonstration programs with special permission (a "waiver") from the Centers for Medicare and Medicaid Services (CMS).[8] Finally, every state in the nation covers treatment for uninsured women diagnosed with breast or cervical cancer under the national early detection program (and in some cases, for women diagnosed through other screening programs); states were given that option in 2000.[9]

Because of these requirements and options, Medicaid—even before the considerable expansion of the program that would come with the successful implementation of the ACA—is inarguably the most financially important U.S. program supporting reproductive health services. Medicaid and CHIP provide comprehensive health insurance coverage for more than nine million women aged 15–44, including 40% of those women with incomes below the poverty level (see chart).[10] The reproductive health–specific expansions serve to heighten Medicaid's importance for such services. The programs paid for 48% of all U.S. births in 2006, including 64% of births resulting from unintended pregnancy;[11] Medicaid accounted for 71% of all federal and state spending on family planning services and supplies that same year.[12] Abortion is one area where Medicaid funding does not dominate; however, about 15% of U.S. abortions—roughly 177,000[12] out of 1.2 million[13] in 2006—are paid for by Medicaid, almost exclusively in the states that make use of their own funds for that purpose.

Expansion Under the ACA

The ACA calls for a substantial expansion to Medicaid by standardizing its eligibility criteria across states and shifting those criteria to focus primarily on income. Starting in January 2014, all states will be required to extend eligibility under the program to all citizens (and legal residents after the five-year bar) with incomes up to 133% of poverty. Those with incomes above this cutoff but below 400% of poverty will be eligible for subsidies to help them afford private insurance coverage purchased via the health insurance exchanges, which are scheduled to be in operation by the same date. To make this as seamless as possible for potential enrollees, the ACA standardizes income eligibility guidelines across programs and pushes states to design a joint enrollment system for Medicaid, CHIP and the exchange subsidies so as to ensure that there is, as many experts call it, "no wrong door" for applicants.

As a result of these provisions under the ACA, Medicaid by 2019 is expected to serve 16 million people who would otherwise be uninsured, according to estimates from the Congressional Budget Office (CBO); that amounts to half of the ACA's projected impact on expanding U.S. insurance coverage.[14] States are permitted to implement some or all of the Medicaid expansion earlier than 2014, and at least three jurisdictions—Connecticut, the District of Columbia and Minnesota—have done so already, to receive federal financial assistance for enrollees whose coverage had previously been funded entirely by the state.

Newly eligible Medicaid enrollees will not necessarily receive the same coverage that states provide for those currently eligible for the program, but all signs point to continued strong coverage for reproductive health care (except abortion). The newly eligible beneficiaries are to be provided packages of services that mirror typical private-sector insurance coverage and may require greater than "nominal" cost-sharing. States were given the authority in 2006 to move some Medicaid enrollees into these so-called benchmark plans, but most have not taken advantage of this option (related article, Spring 2006, page 2).[15] In any case, the ACA takes steps to improve that coverage. Notably, one provision explicitly requires all such plans to cover family planning services and supplies. More broadly, benchmark plans will have to meet the same essential health benefits requirements that will apply to plans in the new exchanges, starting in 2014. That package is required to include maternity care and—when filled out by the Department of Health and Human Services (DHHS) perhaps later in 2011—is expected to capture a wide range of other reproductive health services (related article, Summer 2010, page 13).

Conservatives Push Back

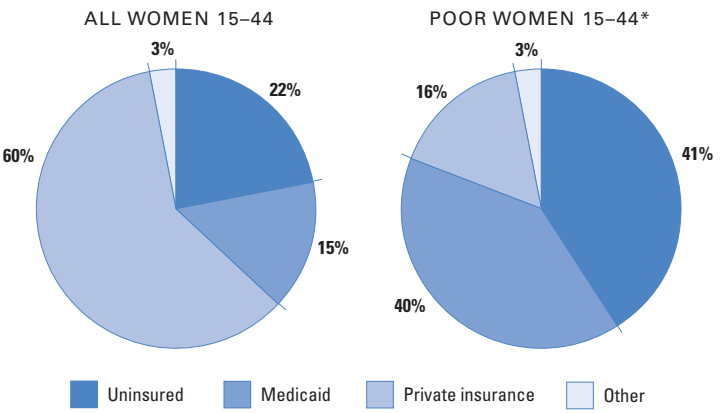
Although the Medicaid expansion would have an enormous impact by bringing so many uninsured Americans into the health care system, those newly eligible Medicaid beneficiaries should be a relative bargain, particularly for states. Because of Medicaid's current eligibility guidelines, most of the newly eligible beneficiaries will be young, childless adults without any disabilities; they are also more likely to be male than female, because young men are especially likely to be uninsured today.[16] All of these characteristics are associated with the use of fewer health services. Indeed, nonelderly, nondisabled adults currently account for 25% of Medicaid enrollees but only 12% of the program's expenditures on benefits.[17] Beyond that, the federal government will reimburse states for a far higher proportion of their costs for newly eligible individuals than for traditional enrollees—initially, 100% of the costs and then decreasing in steps to 90%. Even that eventual rate compares quite favorably to what states receive for currently eligible individuals: from 50% to about 75% of costs, depending on states' relative income levels.

Even so, the reaction to the ACA's Medicaid provisions from most state governors has been far from enthusiastic. Politics are at play, naturally, with Republican governors and legislators lining up with their party mates in Congress to call with near unanimity for the repeal of the ACA. Their specific objections on the Medicaid front, however, reflect their own priorities and, in fact, are less directed to the eligibility expansion per se than to other provisions in the law.

In the short term, objections from conservatives at the state level center on federal requirements that prevent states from scaling back their

AN OUTSIZED ROLE

Medicaid provides health insurance coverage for 15% of reproductive-aged women, including 40% of those who are poor.



*Individuals in families with incomes below the federal poverty level. *Source:* Reference 10.

Medicaid efforts during their ongoing budgetary crises. A pair of maintenance of effort (MOE) requirements—first from the American Recovery and Reinvestment Act (ARRA) of 2009 and later from the ACA itself—require states to maintain, with few exceptions, the eligibility standards, methodologies and procedures they had in effect for Medicaid in July 2008, before ARRA was passed. All states accepted that requirement initially in exchange for a temporary boost to federal Medicaid reimbursement rates, amounting to about $100 billion over two and a half years. That influx of federal money helped states pay for increases in Medicaid enrollment, prevent cutbacks in benefits and provider payment rates, and close budget shortfalls.[18] Now, with those enhanced rates having expired in June 2011, states are facing those threats anew and many are chaffing at the continuing MOE requirement under the ACA.

Looking beyond 2014, state budget hawks do not primarily fear the costs of newly eligible individuals, given that the federal government will pay for nearly all those costs; rather, they fear the costs of individuals who are already eligible for Medicaid but have not yet enrolled. Because of the ACA's individual mandate—the requirement that nearly all Americans have health insurance or else pay a tax penalty, starting in 2014—and the law's provisions to streamline enrollment, many states and outside experts expect enrollment among those already eligible to increase substantially.[19,20] (Take-up rates among currently eligible adults average 62% and vary considerably across states.[21]) Indeed, the ACA's vision runs counter to a long-standing but rarely acknowledged tactic taken by many states to limit Medicaid costs by erecting bureaucratic obstacles to enrollment, a tactic that Congress had earlier begun discouraging through efforts to facilitate enrollment of children under CHIP and Medicaid.[22,23]

As an alternative vision for the program, the Republican Governors Association in June 2011 issued a set of seven principles for "reforming" Medicaid that call for "flexible, accountable financing mechanisms" such as block grants; an emphasis on quality and "value" over numbers of people served; enforcing "reasonable cost sharing for those able to pay"; and increased enrollment of Medicaid recipients in private insurance plans.[24]

Meanwhile, whereas the governors have discussed a Medicaid block grant as one of multiple options for addressing Medicaid financing, House Republicans have embraced it as their central tactic. It was one of the key cost-saving provisions of the 2012 budget proposal authored by Rep. Ryan and was reportedly sought by Republican negotiators during the debt ceiling talks. Such proposals have been offered repeatedly over Medicaid's history by conservative policymakers and analysts (related article, August 2004, page 4).

From a state's point of view, a block grant is attractive because it would provide greater control over the program and greater predictability in costs. Predictability in costs is also attractive from a federal point of view, but the block grant structure would guarantee savings only if the grant amount is set to rise at a pace slower than projected cost increases in the program's current form. Indeed, the Ryan plan would accomplish this goal by pegging states' grants to population growth and overall inflation (which rises slower than inflation for medical care), a standard that CBO projects would result in 35% less funding in 2022 and 49% less in 2030 than would be the case under current law.[25] The Center on Budget and Policy Priorities contends that a rollback in funding of this magnitude, combined with increased state flexibility, would inevitably lead to substantial restrictions in enrollment, services and access to providers, along with increases in patient cost-sharing.[26] If that scenario were to prove true, the impact on reproductive health care could be considerable.

The Obama administration has responded to these attacks in part by emphasizing and endorsing the flexibility states already have in designing their Medicaid programs. For example, Secretary of DHHS Kathleen Sebelius, formerly the governor of Kansas, issued an open letter to the nation's governors in February 2011 asserting the department's commitment to "responsive-

ness and flexibility" in helping states "achieve both short-term savings and longer-term sustainability while providing high-quality care" and outlining states' existing "options and opportunities to more efficiently manage Medicaid."[27] That list already includes options for changing benefit packages and cost-sharing, as well as managing care and costs for the most expensive Medicaid populations, wringing additional savings out of prescription drug purchases, and detecting and preventing fraud.

At the same time, the administration is taking steps to protect Medicaid against further attempts to limit its reach. On a substantive level, CMS has looked to curtail erosion on one of the program's most vulnerable fronts: payment rates to providers, which states have typically set well below those paid by both private insurance and Medicare. Low payment rates, in turn, have already led to access problems for patients, with only 42% of primary care physicians accepting all or most new Medicaid patients, versus 61% for Medicare patients and 84% for privately insured patients.[28] In May 2011, CMS issued proposed regulations that would establish a framework to guide states in ensuring that payment rates are consistent with statutory requirements to ensure "efficiency, economy and quality of care" and an adequate network of providers.[29]

On a political level, the administration and other supporters of the ACA have touted projections that counter conservatives' argument that the ACA will increase states' costs. Instead, according to what supporters argue are more complete projections, the ACA will result in considerable net savings for states, with new spending offset by new revenues and reductions in costs, particularly for uncompensated care to the uninsured.[19] They also continue to tout CBO projections that the ACA will reduce overall federal expenditures as well.[14]

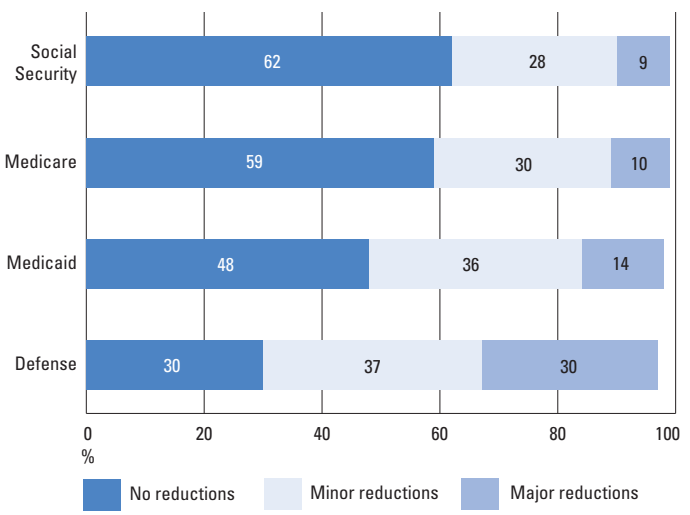
Where Will Medicaid End Up?

President Obama and Democrats in Congress have a vested interest in countering conservatives' attempts to expand states' "flexibility" with regard to Medicaid. The ACA stands as their trademark legislative achievement since Obama took office, and the expansion of Medicaid is a foundation of that achievement. Proposals to scale back Medicaid would not only eliminate that achievement, but would move the country's health care system a considerable distance in the opposite direction. From both a policy and a political perspective, the two parties' approaches to Medicaid present diametrically opposed visions.

Nevertheless, reports from the months-long debt ceiling negotiations indicated that substantial cuts to Medicaid were floated not only by Republicans but by Democrats as well. Thus, Medicaid advocates were cautiously relieved that the program was spared during the initial $900 billion round of cuts under the debt ceiling agreement and that it was made exempt from $1.2 trillion in across-the-board cuts that would be triggered if Congress fails to agree on further deficit reduction in November. Yet, Medicaid and the ACA will still be on the table during that second round of negotiations and may be expected to be major points of contention into next year and beyond. This danger comes as little surprise to many of the program's advocates. Politically, Medicaid has traditionally been seen as having considerably less political clout

SOLID SUPPORT

The idea of major reductions to Medicaid is nearly as unpopular among Americans as it is for Social Security or Medicare, and twice as many people support major reductions to defense spending.



Source: Reference 30.

than the other key drivers of federal spending: Social Security, Medicare and defense spending, as well as tax expenditures such as the home mortgage deduction and the tax exemptions for private health insurance.

Conventional wisdom may be mistaken in this case. A series of 2011 polls by the Kaiser Family Foundation have found that public support for major reductions in spending is only marginally higher for Medicaid than for Medicare or Social Security (see chart, page 15).[30] Six in 10 respondents opposed the idea of block granting Medicaid.[31] Support for the program predictably followed party lines, but it also mirrored respondents' personal connection to the program—and half of them (51%) reported having received assistance from Medicaid themselves or having a friend or family member who had received such assistance.[31] That makes perfect sense, given the outsized role of Medicaid in covering several basic types of care for Americans young and old, such as maternity care (half of all U.S. births) and nursing home payments and other long-term care (40% of all U.S. expenditures).[32] If the ACA survives to be fully implemented, the American public's connection to and support for Medicaid should only further expand.

Although newly emboldened social conservatives have brought to bear an arsenal of overt attacks on access to sexual and reproductive health services (related article, page 6), the debate over Medicaid—at least so far—has been almost entirely divorced from those particular ideological battles. Nevertheless, because Medicaid is the financial foundation of these services for low-income women and men in the United States, this ongoing tug-of-war over the future of the program is one of the most important battles that reproductive health advocates currently face. If the ACA is successfully implemented, it should mean more and better coverage under Medicaid for the reproductive health needs of millions of U.S. citizens. If instead Medicaid were reshaped to restrict costs, enrollment and care, then the future of the American safety-net would be in serious jeopardy.

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Continued on page 23

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