March 2025

National Family Planning & Reproductive Health Association

FACT SHEET

MEDICAID

A Cornerstone of Publicly Funded Family Planning Care

Medicaid is a federal-state partnership to provide health care coverage for low- income and other individuals in which states reimburse providers or managed care organizations and the federal government matches state dollars spent. As a mandatory spending program, funding does not need to be appropriated by Congress annually and there is no cap on funding. This structure helps ensure that states have the resources needed to respond to changes in the economy, such as when a recession causes more people to be in need of, and eligible for, Medicaid.

Since the 1980s, Medicaid has been the predominant funding source for publicly funded family planning care, particularly in states that have expanded their Medicaid eligibility for family planning.[1] Medicaid's importance in providing publicly funded family planning care has only grown as states have expanded Medicaid eligibility under the Affordable Care Act (ACA) for Americans with incomes up to 138% of the federal poverty level (FPL). Currently, 41 states and the District of Columbia have expanded Medicaid eligibility, helping 16.6 million people gain coverage since the Medicaid expansion began in October 2013.[2] Continued full federal support for Medicaid, including Medicaid expansion, is critical to the ability of low-income people to access family planning and other preventive health services.

FAMILY PLANNING IS A REQUIRED SERVICE UNDER MEDICAID

- In 1972, Congress amended the Medicaid program to require that states cover family planning services and supplies.
- Medicaid-funded family planning includes a broad range of family planning services and supplies, including the full range of contraceptive methods, Pap tests, and other associated examinations and labs.[3]
- This mandatory benefit is provided at an enhanced matching rate to states, with the federal government paying 90% of the cost.[4]

- Federal law also requires Medicaid-funded family planning be exempt from cost-sharing requirements, such as premiums, co-pays, and deductibles.[5]

FAMILY PLANNING AND "FREEDOM OF CHOICE"

- Federal law requires states to allow Medicaid beneficiaries to receive family planning services from any qualified Medicaid provider, even if that provider is outside of the beneficiary's Medicaid managed care network; this principle is referred to as "freedom of choice" or "free choice of provider."[6]

- In recent years, Medicaid's freedom-of-choice protections have come under attack, with some state governments seeking to exclude abortion providers from participating in their states' Medicaid programs. Some states have used administrative action to achieve this goal. In January 2020, the Trump administration reversed the position of previous administrations on the topic and approved a section 1115 family planning expansion waiver from Texas which waived free choice of provider. [7]

- A case is pending in front of the Supreme Court, Medina v. Planned Parenthood South Atlantic, with oral argument scheduled for April 2, 2025. The case deals with free choice of provider in Medicaid and a decision is expected in the summer of 2025.

MEDICAID FAMILY PLANNING EXPANSION PROGRAMS

- Since the 1990s, many states have broadened eligibility for their Medicaid programs to provide family planning services and supplies to individuals who are not categorically eligible for Medicaid.[8]

- Originally these expansions were done through a Medicaid waiver authorized by §1115 of the Social Security Act. Recognizing the effectiveness of these programs, Congress included in the ACA a provision giving states the option to amend their state Medicaid plans to expand eligibility for family planning services and supplies to individuals who are not pregnant and who have an income that does not exceed the income-eligibility level set by the state for coverage for pregnancy-related care.[10]

- Thirty states operate a Medicaid family planning expansion program, 19 of which operate their expansion through such a state plan amendment (SPA).[11]

CURRENT POLICY DISCUSSIONS

- Proposed changes to Medicaid's financing and structure—such as turning Medicaid into a block grant program, implementing a per-capita cap, or imposing work requirements—would shift risks and costs to states and increase the likelihood that many poor and low-income individuals will go without care or seek uncompensated care in our nation's emergency rooms, resulting in increased health care costs. These changes would likely result in reductions in eligibility, benefits, protections for enrollees, and provider reimbursement rates.[13]

- Maintaining the current federal-state matching structure, where the federal government pays a portion of states' costs in providing care to Medicaid enrollees, is integral to ensuring coverage for millions of people and continued provision of vital public health services.

- Furthermore, proposals to waive or weaken critical, longstanding beneficiary protections would only act as barriers to care, undermining the health and well-being of millions of poor and low-income Americans. States already have significant flexibility in administering their Medicaid programs; they are currently given broad discretion over defining benefits, choosing delivery care models, and adjusting how providers and plans are paid. Attempts to waive or eliminate Medicaid's fundamental requirements should be soundly rejected.

1 FY 2015 data. Kinsey Hasstedt, Adam Sonfield and Rachel Benson Gold, "Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980–2015," Guttmacher Institute (April 2017). https://www.guttmacher.org/report/public-funding-family-planning-abortion-services-fy-1980-2015

2 Medicaid Expansion Enrollment. KFF State Health Facts (June 2024). https://www.kff.org/affordable-care-act/state-indicator/medicaid-expansion-enrollment/

3 Usha Ranji, Yali Bair, and Alina Salganicoff, "Medicaid Family Planning Policy," Kaiser Family Foundation (February 2016). http://kff.org/report-section/medicaid-and-family-planning-medicaid-family-planning-policy/.

4 Ibid.

5 5 42 U.S.C. § 1916(a)(2)(D).

6 42 U.S.C. § 1396a(a)(23); 42 U.S.C. § 1396n(b).

7 Medina v. Fabiola de Liban and Jane Perkins. "Planned Parenthood of South Atlantic: Explainer on the Impact on Medicaid and Sexual and Reproductive Health," National Health Law Program (NHeLP), January 31, 2025. https://healthlaw.org/medina-v-planned-parenthood-of-south-atlantic-explainer-on-the-impact-on-medicaid-and-sexual-and-reproductive-health/

7 Rachel Benson Gold, "Back to Center Stage: ACA Decision Gives New Significance to Medicaid Family Planning Expansions," Guttmacher Policy Review, 15.4 (Fall 2012). http://www.guttmacher.org/pubs/gpr/15/4/gpr150413.html.

8 Adam Thomas, "Policy Solutions for Preventing Unplanned Pregnancy," Brookings Institution (March 2012). http://www.brookings.edu/research/reports/2012/03/unplanned- pregnancy-thomas.

9 For more on Medicaid family planning expansions, see "Medicaid Family Planning Expansion Programs," available on NFPRHA's website at www.nationalfamilyplanning.org.

10 KFF, "States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid,", accessed 2025, https://www.kff.org/medicaid/state-indicator/family-planning-services-waivers.

11 For more on the continuing importance of Medicaid family planning expansion programs, see "Medicaid Family Planning Expansion Programs: Essential Coverage Post-ACA Implementation," available on NFPRHA's website at www.nationalfamilyplanning.org.

12 Edwin Park, "Medicaid Block Grant Would Slash Federal Funding, Shift Costs to States, and Leave Millions More Uninsured," Center on Budget and Policy Priorities (November 30, 2016). http://www.cbpp.org/research/health/medicaid-block-grant-would-slash-federal-funding-shift-costs-to-states-and-leave.