BLACK WOMEN'S HEALTH IMPERATIVE

Protecting Medicaid for Black Women and Girls

Policy Priorities to Strengthen Coverage, Affordability, and Reproductive Justice

OUR POSITION

Medicaid is a critical pillar of our country's healthcare system and a cornerstone of healthcare access for Black women and girls.[1] When Medicaid functions at its full capacity, it supports wellness at every stage – from preventive pediatric care to reproductive and maternal health, chronic disease management, and aging with dignity. When it's weakened, Black women and girls feel the consequences disproportionately. **The Black Women's Health Imperative (BWHI) is committed to protecting Medicaid from harmful restrictions on its core functions and advancing state and federal reforms that strengthen the program's capacity to meet Black women's health needs across the lifespan.**

MEDICAID COVERAGE FOR BLACK WOMEN AND GIRLS		
1 in 4, or over 3.3 million, Black women rely on Medicaid for healthcare coverage.[2]	**52% of Black girls** under 18 are covered by Medicaid.[3]	**Medicaid pays for 65% of births by Black mothers** – making it the largest payer for Black maternal health.[4]

THE MEDICAID LANDSCAPE: ESSENTIAL POLICIES, ONGOING LIMITS, AND RISING THREATS

Medicaid programs across the U.S. have utilized several core provisions, including Medicaid expansion, the 340B Drug Pricing Program, pregnancy-based coverage through the postpartum period, and reimbursement for doula and midwifery care, to expand access to care for millions. These policies bring us closer to a society where healthcare is accessible for all – not only those that can afford it.

Yet, even as these policies have fostered progress, numerous policies continue to limit access to care. Longstanding provisions like the Hyde Amendment restrict access to abortion services for Medicaid enrollees, and across the country, efforts to weaken key Medicaid protections are on the rise.

Below, we outline the Medicaid policies BWHI supports and opposes, and the federal and state actions we believe are necessary to ensure that Medicaid works for all Black women and girls.

MEDICAID EXPANSION

Forty states and Washington, DC have implemented Medicaid expansion under the Affordable Care Act, expanding coverage to adults with incomes up to 138% of the Federal Poverty Level ($21,597 in 2025).[5] States that expand Medicaid receive a 90% federal matching rate for their expansion enrollees, who now make up about 24% of all Medicaid beneficiaries.[6,7]

Despite gains in coverage, Medicaid expansion states and enrollees continue to be targeted in federal proposals aimed at reducing access and spending. In fact, the recent reconciliation package signed into law by President Trump imposes a series of harmful restrictions on expansion states: harsh work requirements for adults aged 19 to 64; more frequent eligibility redeterminations; mandatory copays up to $35 for certain services that were previously free or lower cost; permission for providers to turn away patients who cannot pay; and limits on provider taxes, which states use to fund their Medicaid programs.[8]

POLICY RECOMMENDATIONS

- **Repeal work requirements and additional eligibility redeterminations**, which are associated with coverage loss due to administrative churn and procedural disenrollments, rather than ineligibility.[9]
- **Reinstate state flexibility to use provider taxes** so states can continue to reliably finance their Medicaid programs.

MEDICAID'S 340B DRUG PRICING PROGRAM

The 340B Drug Pricing Program was established to protect safety-net hospitals and the low-income communities they serve from rising drug prices by allowing eligible entities to purchase medications at reduced prices.[10,11] Ideally, the program would lower prescription costs for patients and expand access to essential services like dental care, mental health support, HIV treatment, and more. While 340B was well intended, its benefits have not consistently reached the patients it was created to help.

Disproportionate Share Hospitals (DSHs), which serve a higher percentage of low-income patients and receive funding from the Centers for Medicare and Medicaid Services to help cover the cost of care for uninsured patients, receive 80% of the 340B program's money.[12,13] However, unlike other eligible entities such as federally qualified health centers and Ryan White clinics, DSHs are not required to reinvest those savings into the communities they serve.[14] Most 340B hospitals also are not obligated to pass on medication discounts or financial assistance to patients, allowing them to charge full price and keep the profit.[15] In many cases, these hospitals provide minimal free or discounted care and instead, use aggressive billing practices to collect medical debt from patients.[16] The lack of consistent reporting standards across 340B-eligible entities, particularly for the entities that profit the most, undermines the program's intended impact of improving healthcare access for medically underserved communities.

POLICY RECOMMENDATIONS

- **Reform hospital eligibility** to prioritize providers that serve large numbers of low-income, underinsured, and uninsured patients.
- **Require all 340B entities to report revenue and how savings are used** to standardize transparency and accountability.
- **Establish sliding scale pricing for patients and set minimum charity care standards** for 340B entities.

PREGNANCY-BASED MEDICAID ELIGIBILITY AND POSTPARTUM COVERAGE

Pregnancy is a common entry point into Medicaid coverage, particularly for women of reproductive age.[17] Under federal law, states are required to provide pregnancy-based Medicaid coverage to eligible individuals through 60 days postpartum.[18] Today, almost every state – including Washington, DC – has adopted the new option to extend Medicaid postpartum coverage to 12 months, except for Wisconsin.[19]

Black women are over three times more likely to die from pregnancy-related complications than White women, and over 60% of pregnancy-related deaths occur during the postpartum period – most between 42 and 365 days after delivery. [20,21] These facts highlight the lifesaving potential of Medicaid coverage beyond 60 days. Over four in five pregnancy-related deaths are preventable, meaning timely postpartum care could lead to earlier interventions and healthier outcomes.[22] And with one in eight Black women uninsured, continued access to Medicaid after childbirth is a meaningful, though temporary, step to closing persistent gaps in maternal health outcomes and health coverage.[23]

POLICY RECOMMENDATION

- **Protect pregnancy-based Medicaid eligibility and the 12-month postpartum coverage option** as a permanent, national standard.

MEDICAID REIMBURSEMENT FOR DOULAS AND MIDWIVES

Doulas and midwives play an important role in improving maternal health outcomes and birthing experiences. Doulas are nonclinical birth workers who offer valuable advocacy, physical comfort, emotional support, and information before, during, and after birth.[24] Midwives, who are trained clinical providers, deliver comprehensive care throughout the perinatal period, often offering a low-intervention alternative to traditional obstetric care.[25] Both types of care have been linked to lower rates of maternal and infant complications and cesarean births, as well as higher rates of breastfeeding and overall satisfaction among birthing people.[26]

Even with this evidence, Medicaid reimbursement for doulas and midwives is inconsistent. Currently, 23 states reimburse doulas, with most others exploring and finalizing pathways to do so.[27] For midwifery care, only 19 states reimburse both certified nurse midwives (CNMs) and other trained, licensed midwives, while 32 states reimburse only CNMs.[28] Cost and lack of coverage are among the greatest barriers to accessing doula and midwifery care, both for patients and for the sustainability of these workforces.[29]

POLICY RECOMMENDATIONS

- **Expand equitable Medicaid reimbursement for doula services**.
- **Expand equitable Medicaid reimbursement for all licensed midwives**, not just CNMs.

HYDE AMENDMENT

The Hyde Amendment is a federal provision that prohibits the use of federal funds to be used to pay for abortion services under Medicaid, except in cases of rape, incest, or when the life of the mother is at risk.[30,31] It has been attached to annual Congressional spending bills since 1976.[32]

While 16 states provide funding for abortion for their Medicaid enrollees, 34 other states, and Washington, DC do not.[33] This leaves 7.8 million women of reproductive age (15-49) enrolled in Medicaid without abortion coverage, half of which are women of color.[34] Because Medicaid primarily serves low-income individuals, lack of abortion coverage forces many of these women to take on additional financial burdens, including out-of-pocket travel costs, to access care.[35]

POLICY RECOMMENDATIONS

- **Remove the Hyde Amendment** from future spending bills.
- **Pass the Equal Access to Abortion Coverage in Health Insurance (EACH) Act**, which requires federal healthcare programs including Medicaid to cover abortion services.

Endnotes

1 In 1965, President Lyndon B. Johnson signed the Medicare and Medicaid Act into law, establishing Medicaid as a health insurance program for low-income individuals. Over the last 60 years, Medicaid has expanded to provide health insurance coverage for low-income families, pregnant women, people with disabilities, and people with long-term care needs. *History*. CMS.gov. (2024, September 10). https://www.cms.gov/about-cms/who-we-are/history

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