WOMEN'S ISSUE BRIEF
AN UPDATE ON WOMEN'S HEALTH POLICY

THE HENRY J. KAISER FAMILY FOUNDATION

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MEDICAID'S ROLE FOR WOMEN ACROSS THE LIFESPAN: CURRENT ISSUES AND THE IMPACT OF THE AFFORDABLE CARE ACT

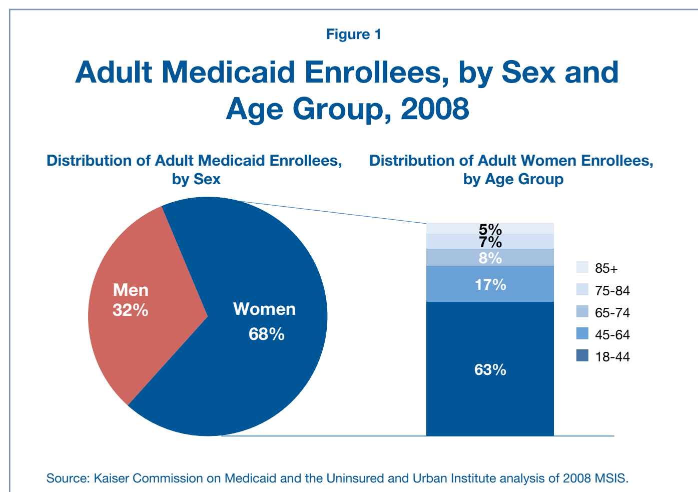
Medicaid, a jointly financed state-federal health coverage program for the poor and low-income, provided over 21 million low-income women with basic health and long-term care coverage in 2008. For these women, Medicaid covered a wide range of health services that address health needs throughout their lifespan, including reproductive health care, care for chronic conditions and disabilities, and long-term services. The Affordable Care Act (ACA) will further broaden the reach of Medicaid coverage, as the program will be the major vehicle for expanding health coverage to the low-income uninsured population. The ACA has also authorized a number of changes to Medicaid that will affect access to care for women enrolled in the program. This brief discusses the current state of the program as it affects women and also examines the major changes from the ACA and the impact on women.

ELIGIBILITY POLICY

For a woman to qualify for Medicaid, she must meet both categorical and income criteria. That means she must fit into a certain "category," such as being pregnant, a mother of a child under age 18, a senior citizen, or having a disability. Each of these categorical groups has different income eligibility criteria. The federal government has established minimum income thresholds, but states set specific eligibility levels and can exceed the minimum thresholds, which many states do. As a result, eligibility criteria vary for different groups of beneficiaries as well as between states.

Figure 1

Adult Medicaid Enrollees, by Sex and Age Group, 2008



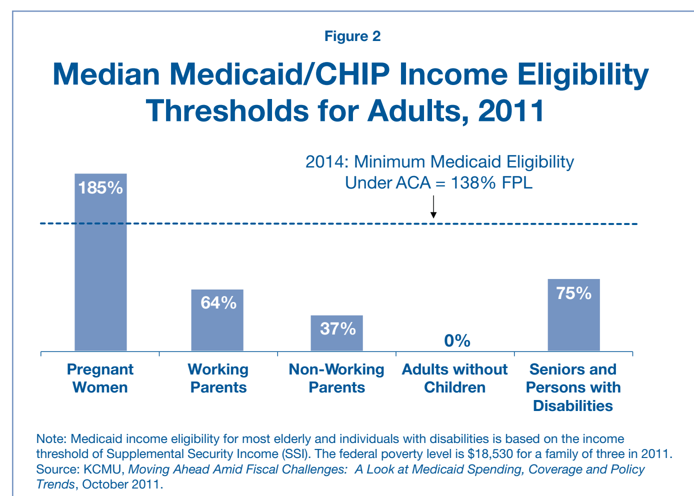
Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2008 MSIS.

Because women are more likely than men to fall into one of the categories and are more likely than men to be poor, more women than men qualify for Medicaid. Among the adult population of Medicaid enrollees, women comprise over two-thirds of beneficiaries (Figure 1). Nonetheless, many poor women do not qualify, no matter how poor they are, because they do not fall into one of the eligibility categories described below.

Pregnant women: Federal law requires states to cover pregnant women with incomes up to 133% of the federal poverty level (FPL)[i] for up to 60 days postpartum (Figure 2). States can extend coverage to pregnant women with incomes up to 185% FPL and even beyond and still receive federal matching funds for their care. Eligibility levels for pregnant women currently range from the minimum requirement of 133% FPL in 9 states to 300% FPL in the District of Columbia, Iowa, and Wisconsin.[1]

Figure 2

Median Medicaid/CHIP Income Eligibility Thresholds for Adults, 2011



Note: Medicaid income eligibility for most elderly and individuals with disabilities is based on the income threshold of Supplemental Security Income (SSI). The federal poverty level is $18,530 for a family of three in 2011.
Source: KCMU, *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends*, October 2011.

Parents with dependent children: The minimum income eligibility threshold for parents with children under 18 varies considerably between states. Income eligibility levels are generally very low and are based on cash assistance levels used by the former Aid to Families with Dependent Children (AFDC) program in 1996.[ii] On average, income eligibility is 64% FPL for working parents and 37% for jobless parents. States can, however, extend coverage to parents with income levels that are a bit higher. As of 2011, income eligibility levels for working parents ranged from 17% FPL in Arkansas to 215% FPL in Minnesota.[2]

[i] The federal poverty level (FPL) is $18,530 for a family of three in 2011. http://aspe.hhs.gov/poverty/11poverty.shtml

[ii] AFDC stands for Aid to Families with Dependent Children and is the former federal welfare program in the United States. It was replaced in 1996 by the Temporary Assistance for Needy Families (TANF) program. For more details, see: http://aspe.hhs.gov/hsp/abbrev/afdc-tanf.htm

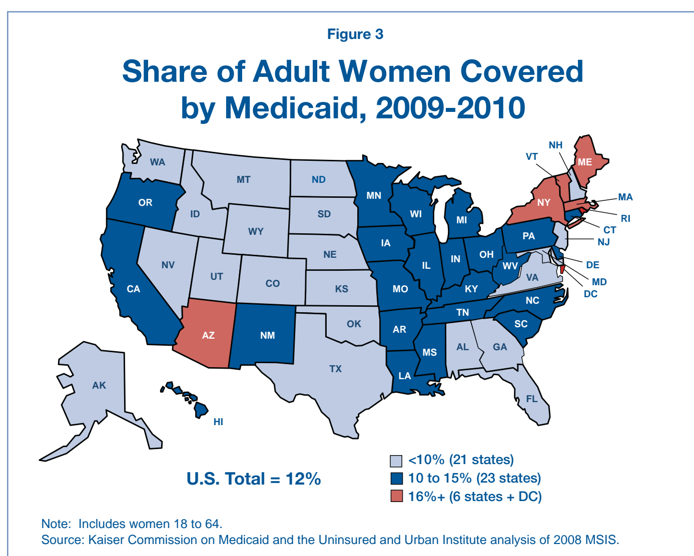
Seniors: Virtually all adults 65 and older receive Medicare. Seniors who are low-income and who qualify for federal Supplemental Security Income (SSI) can receive full Medicaid benefits including long-term care as well as assistance with Medicare cost-sharing. Low-income seniors who are not quite poor enough to qualify for SSI can qualify for assistance with Medicare cost-sharing and deductibles, but are not covered for long-term services such as nursing home stays or in home personal assistance.

Disability: Most people with disabilities on Medicaid qualify because they receive Supplemental Security Income (SSI), as they are deemed to have a disability that is so severe they cannot participate in any "substantial gainful activity." Others who are sick or disabled can also qualify if they "spend down" their assets to meet their state's income threshold. Furthermore, in 33 states and the District of Columbia, a sick or disabled individual can qualify for Medicaid if her medical expenses are so high that she meets the state's "medically needy" income standard.[3] Like seniors, persons with disabilities on Medicaid who qualify for Medicare are also eligible for assistance with Medicare premiums and cost-sharing expenses.

Eligibility criteria for each category as well as population characteristics vary greatly between states, resulting in state-level differences in the share of women covered by Medicaid (Figure 3). In 2014, Medicaid eligibility policies will change as the ACA coverage expansions are implemented. The major change is that Medicaid will be extended to many uninsured citizens and legal residents with incomes up to 138% FPL, *without* categorical requirements.[iii] It is estimated that millions of women who are currently uninsured will qualify for Medicaid at that time, and the numbers will vary greatly across states (Table 1 – see back page).[4]

Figure 3

Share of Adult Women Covered by Medicaid, 2009-2010



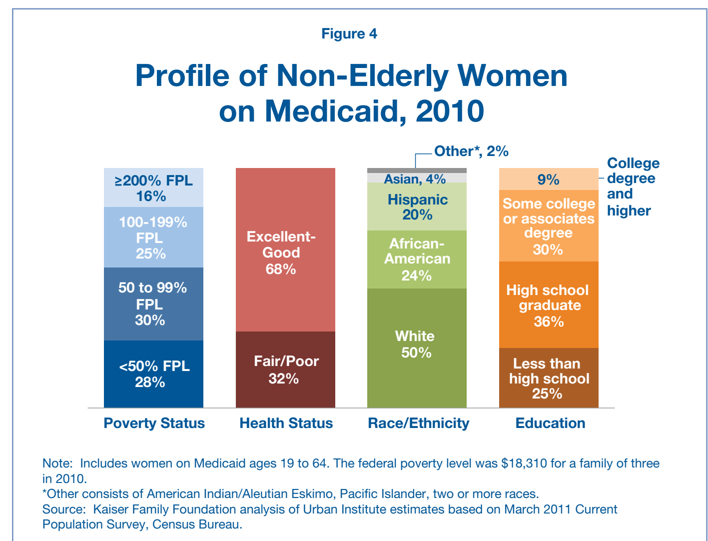
Note: Includes women 18 to 64.
Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2008 MSIS.

PROFILE OF WOMEN ON MEDICAID

In 2008, according to federal Medicaid enrollment data, 69% of adults (age 19 and older) on Medicaid were women and 31% were men.[5] This diverse group of women face many social, economic, and health challenges that affect their ability to receive timely and high quality health care. Women with Medicaid are disproportionately likely to be poor, members of a racial/ethnic minority, in fair or poor health, and to have lower levels of educational attainment (Figure 4). More than half (58%) of non-elderly, adult women on Medicaid who live in the community have family incomes below the poverty level. One quarter (28%) of nonelderly women on Medicaid are very poor, with incomes below 50% of the poverty level, about $9,155 per year for a family of three.

Figure 4

Profile of Non-Elderly Women on Medicaid, 2010



Note: Includes women on Medicaid ages 19 to 64. The federal poverty level was $18,310 for a family of three in 2010.
*Other consists of American Indian/Aleutian Eskimo, Pacific Islander, two or more races.
Source: Kaiser Family Foundation analysis of Urban Institute estimates based on March 2011 Current Population Survey, Census Bureau.

One in four (25%) non-elderly women covered by Medicaid do not have a high school degree, and only 9% have a college degree or higher education level. One-third (32%) of nonelderly women on Medicaid report fair or poor health, compared to 7% of women with private employer-sponsored coverage and 12% of women who are uninsured.[6]

MEDICAID AND WOMEN'S HEALTH ACROSS THE LIFESPAN

At all ages, women make up the majority of beneficiaries on Medicaid (Figure 5). The program pays for a broad range of services important to women at different stages of their lives. This includes hospital and physician services, lab and x-ray services, preventive services, family planning, maternity care, and long-term services such as nursing home care. Each state decides which specific services to cover under Medicaid, within federal guidelines.

[iii] The level in the ACA statute is 133% of the Federal Poverty Level but there is a 5% income disregard that makes the effective level 138% of the FPL.

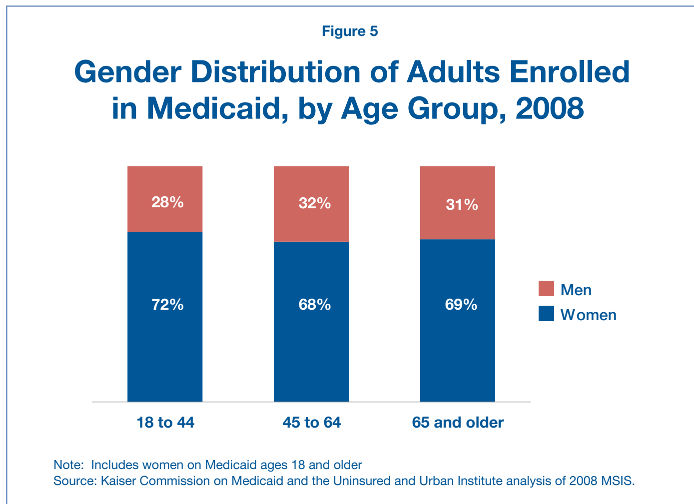


Figure 5

Gender Distribution of Adults Enrolled in Medicaid, by Age Group, 2008

Note: Includes women on Medicaid ages 18 and older
Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2008 MSIS.

Reproductive Years

Nearly two-thirds (63%) of adult women on Medicaid are in their reproductive years (19 to 44). For these women, Medicaid covers a wide range of reproductive health care services, including family planning, STD testing and treatment, screenings such as pap smears, and pregnancy-related care including prenatal services, childbirth, and postpartum care. Medicaid coverage of abortion services, however, is very limited.

Family planning: Family planning is one of the services that the federal government explicitly mandates for coverage in Medicaid. Nationally, Medicaid is the largest financier of publicly funded family planning services, accounting for 71% of all public expenditures.[7] The federal government provides states with an enhanced match of 90 cents for every 10 cents they spend on family planning, higher than for other services (typically matched at a rate between 50% and 76%). States can claim this enhanced match for services and supplies that "are expected to achieve a family planning purpose."[8] Under this guidance, states have broad latitude in what they cover under family planning, and routinely include contraceptive services and supplies, pap smears, STD testing and treatment, and counseling as part of the family planning benefit.[9]

States can impose "nominal" cost sharing for most services under Medicaid, however, family planning services and supplies are exempt. This means women cannot be charged any out-of-pocket costs for these services. The federal government also guarantees "freedom of choice" for Medicaid beneficiaries, which allows them to obtain family planning services from any provider that participates in the program. This allows women to obtain their family planning services from any participating provider or clinic, even one that is out of their managed care network.

In 2011, the state of Indiana enacted a law that prohibits the state from entering into contracts with any entity that performs abortions, including Planned Parenthood, a major provider of family planning services to low-income women. This law is a potential challenge to Medicaid's freedom of choice provision and the Indiana law is being contested in the courts.[10]

In recent years, 27 states have established special family planning programs to extend access to family planning services to women who otherwise do not qualify for full Medicaid benefits. This includes low-income women who are not poor enough to qualify for Medicaid or who have lost Medicaid eligibility after having a baby. Evaluations of these programs suggest they have improved access to contraceptives and averted unintended pregnancies in several states.[11]

Until 2010, states had to obtain special permission (waiver) from the federal government to establish these programs, and it was often a complex process. Under the ACA, the process has been simplified and states can now extend family planning coverage by filing a State Plan Amendment (SPA), which changes their Medicaid programs permanently. As of November 2011, at least six states (CA, NM, OK, SC, VA, WI) have expanded family planning coverage through SPAs (Figure 6).[12]

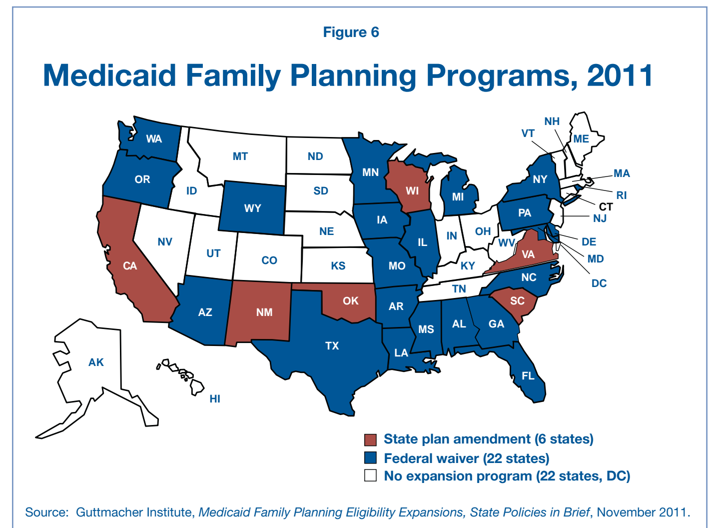


Figure 6

Medicaid Family Planning Programs, 2011

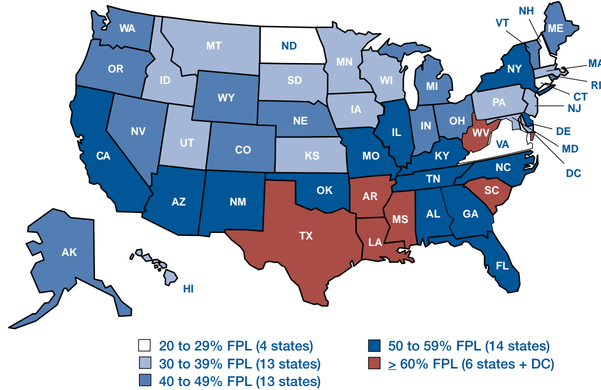
Source: Guttmacher Institute, *Medicaid Family Planning Eligibility Expansions, State Policies in Brief*, November 2011.

Maternity Care: Responding to increases in infant mortality, Medicaid eligibility levels were significantly raised in the late 1980s and 1990s to improve access to early prenatal care to improve birth outcomes. Today, Medicaid is one of the largest payers of pregnancy-related services, financing between an estimated 40% and 50% of all births in the U.S. In six states and DC, Medicaid covers more than 60% of all births (Figure 7).[13,14]

Pregnancy-related hospitalizations and neonatal stays accounted for 50% of all Medicaid hospitalizations in 2008, and maternity procedures accounted for 5 of the top 10 hospital procedures billed to Medicaid.[15] In most states, Medicaid pays for prenatal visits and

Figure 7

Share of Births Covered by Medicaid, 2006



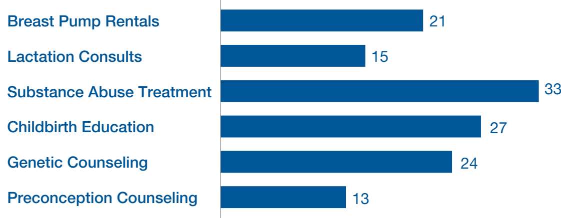
Source: Sonfield, A., Kost, K., Benson Gold, R., & Finer, L.B. (2011). The public cost of births resulting from unintended pregnancies: National and state-level estimates. *Perspectives on Sexual and Reproductive Health* 43(2): 94-102.

supplies such as prenatal vitamins, ultrasound and amniocentesis screenings, smoking cessation, and delivery services, including vaginal and cesarean deliveries.[16] Medicaid also covers postpartum care for 60 days. Coverage for other services, such as counseling and education, substance abuse treatment, and breastfeeding supports, are more limited and vary considerably by state (Figure 8). Legal immigrants are generally banned for receiving federal benefits for at least five years after entry to the United States. States may waive this ban and 17 states have amended their Medicaid programs to allow coverage for pregnant immigrant women who have been in the U.S. legally for less than five years.[17]

Figure 8

State Medicaid Coverage of Prenatal Services, 2009

Number of state Medicaid programs that cover:

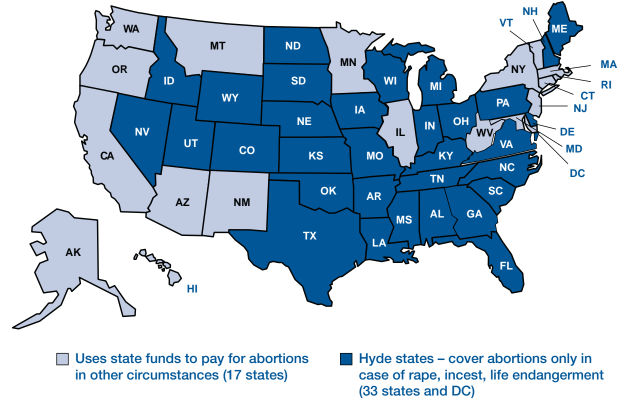


Note: Data available for 43 states and the District of Columbia.
Source: Kaiser Family Foundation, *State Medicaid Coverage of Perinatal Services: Summary of State Survey Findings*, 2009.

Abortion: The federal Hyde Amendment prohibits federal spending on abortions, except in cases of rape, incest, or when the woman's life is in danger, and does not make an exception for the health of the woman. States may use their own unmatched funds to cover abortions in other circumstances. In 2011, 17 states provided coverage of abortion considered to be "medically necessary" and paid for this using only state funds (Figure 9). Under the ACA, the same restrictions will apply to women who are newly eligible for Medicaid coverage.

Figure 9

Abortion Financing Under Medicaid, 2011



Source: Guttmacher Institute, *State Funding of Abortion Under Medicaid, State Policies in Brief*, September 2011.

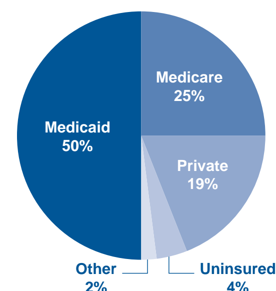
Mid-life Years

As women age, their health needs shift from reproductive care to greater need for screening and management of chronic diseases, mental health care, and disability care (although many women in their reproductive years also have these health needs).

Women with disabilities: Medicaid plays a critical role financing care for women with disabilities, providing assistance with a variety of medical and supportive services. These women have a broad range of physical and mental disabilities, including physical impairments, severe mental illnesses, and specific conditions such as muscular dystrophy, cystic fibrosis, and HIV/AIDS. Half of women ages 21-64 with disabilities in the U.S. have Medicaid coverage (Figure 10). Among the benefits that Medicaid covers for women with disabilities are rehabilitation, transportation, and therapeutic services, which help people with disabilities live independently and are not typically covered by private health insurance plans. Long-term services, including home health care, are another major health benefit for women with disabilities.

Figure 10

Health Coverage of Non-Institutionalized Women with Disabilities, 2008



Notes: Includes women ages 21 to 64 with permanent physical or mental disabilities who live in a community dwelling. Does not include women living in institutionalized settings. Medicaid includes women with Medicaid only, Medicaid and private coverage, Medicaid and Medicare. Other includes women with other public programs, such as Tricare.
Source: Kaiser Family Foundation/Urban Institute analysis of the 2009 American Community Survey.

Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA): In 2000, Congress passed a law allowing states to extend Medicaid coverage for cancer treatment to uninsured women diagnosed with breast or cervical cancer through a federal screening program. The option was adopted by all states, although there is considerable variation in how the program is operated, with some states using very restrictive eligibility guidelines and others casting a broader net to cover more affected women. The Government Accountability Office found that in states with much more restrictive eligibility policies for this program far fewer women with breast and cervical cancer have been served and per capita spending on treatment varied considerably by state.[18]

Seniors

"Dual Eligible" Beneficiaries: While most seniors have coverage through Medicare, some people have both Medicare and Medicaid coverage, and are referred to as "dual eligible" beneficiaries. Dual eligible beneficiaries typically qualify for both programs because they are seniors or younger persons with serious disabilities who have very low incomes. They tend to have extensive health needs, but only those who are very poor or face catastrophic medical costs can qualify. There are more than 9 million dual eligibles, and women account for 62% of this group.[19]

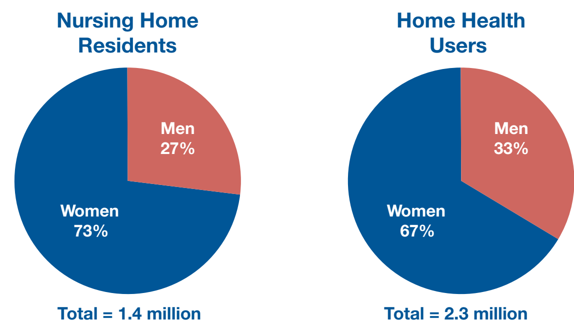
Dual eligible beneficiaries fall into two groups – those who receive full Medicaid coverage and those who receive partial coverage because they have slightly higher incomes. Most have full Medicaid, and receive coverage for services that Medicare does not currently cover, such as nursing home stays and dental and vision care. This group also receives Medicaid coverage for Medicare's out-of-pocket costs, such as deductibles and co-payments. Dual eligible beneficiaries with slightly higher incomes, receive partial Medicaid, which is limited to assistance with Medicare premiums and some of Medicare's cost-sharing requirements.

Long-term services: Since women are more likely to live longer and experience higher rates of chronic illness and disability than men, they are more likely to require long-term services in their lifetime. Approximately seven in ten (73%) nursing home residents and two-thirds (67%) of people receiving home health care are women (Figure 11). This care can be extremely costly—a year in a nursing home averages more than $70,000 annually —and have devastating economic consequences for women on fixed incomes.[20]

Medicaid finances 40% of long-term care expenditures[21], in part, because Medicare does not provide long-term services coverage and private long-term insurance is very expensive and may not cover much of the costs. Medicaid coverage for long-term

Figure 11

Distribution of Nursing Home Residents and Home Health Users, by Gender, 2008



Total = 1.4 million

Total = 2.3 million

Note: Nursing home residents refer to those ages.65 and older
Source: Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey

services includes nursing home stays, as well as community-based supports, but the exact scope and level of coverage varies greatly between states.

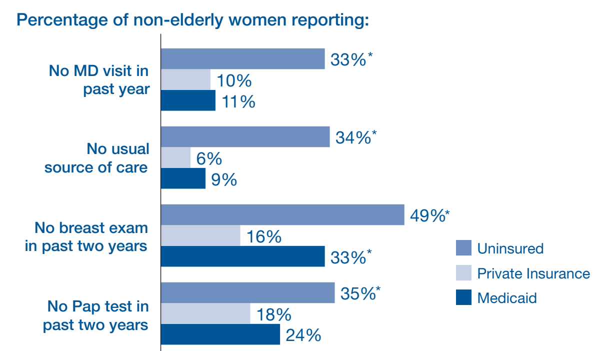
ACCESS TO CARE

Medicaid has been shown to improve access to care for low-income women. Compared to their uninsured counterparts, women on Medicaid experience fewer barriers to care and on several measures have utilization rates comparable to women with private insurance (Figure 12).[22]

Figure 12

Women's Access Barriers by Insurance Coverage, 2008

Percentage of non-elderly women reporting:



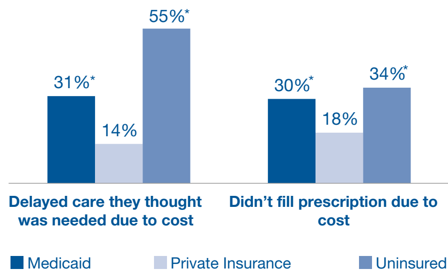
Note: Includes women 18 to 64. *Significantly different from Private Insurance, p<.05.
Source: Kaiser Family Foundation, *2008 Kaiser Women's Health Survey*.

Women on Medicaid are also much less likely to face cost barriers than uninsured women, but affordability is still a problem for many women in the program (Figure 13). This is because some states may impose limits on the number of visits or number of prescriptions that Medicaid will cover. In addition, many states charge cost-sharing to varying degrees on either non-preventive physician visits (23 states), emergency room visits (17 states), or hospitalizations (24 states) for parents.

Figure 13

Health Care Cost Barriers Experienced by Women, by Insurance Status, 2008

Percentage of non-elderly women reporting that in the past year they:



Note: Includes women 18 to 64.
*Significantly different from Private, p<.05.
Source: Kaiser Family Foundation, *2008 Kaiser Women's Health Survey*

Most states also charge copayments for prescription drugs for non-pregnant adults. Approximately one-third of women on Medicaid report that they couldn't obtain needed care (31%) or fill a prescription (30%) because of the cost. As the economy has continued to stagnate and Medicaid's roles have grown, more states have turned to cost-sharing to help alleviate costs, and some states have requested federal permission to charge co-payments higher than the typical nominal amounts.[23] States are not permitted to charge cost-sharing to pregnant women.

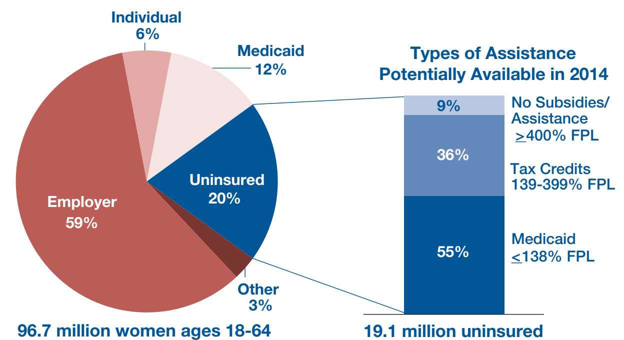
Another long-standing challenge with Medicaid has been limited participation by private physicians, particularly specialists, largely due to low payments to physicians relative to Medicare and private insurers. For example, Medicaid payments to providers equal 72% of Medicare fees on average, and this ratio varies across states, and in many states is even lower.[24] The ACA requires states to raise Medicaid reimbursement rates for primary care providers up to at least Medicare levels, with the federal government covering the costs through 2014. Medicaid beneficiaries are also more likely to live in areas with shortages of providers, which can limit the range of providers available to this population. As a result of these challenges, a substantial share of women on Medicaid relies on clinics and hospital outpatient departments for their care instead of private doctors. Among women on Medicaid who reported a usual source of care, only 37% said it was a private doctor or an HMO compared to 72% of those with private coverage. Women on Medicaid (30%) are more likely to report problems seeing a specialist than those with private insurance (12%), but less likely than those who are uninsured (43%).[25] Limited access to specialists could compromise care for women with disabilities and ongoing chronic illnesses, as well as those who need obstetric care.

MEDICAID AND HEALTH REFORM

The passage of the ACA has brought major changes to insurance coverage for low-income women, including changes to the Medicaid program. Medicaid will be the foundation of health coverage expansions to very low-income women. Because there will no longer be categorical requirements for eligibility, women who have no children or are not pregnant will now be eligible for coverage if their income is below 138% of the federal poverty level. Current coverage data suggest that as many as 10 million currently uninsured women could qualify for Medicaid by 2014 based on their current income levels (Figure 14). However, undocumented immigrants will not qualify for public coverage, so not all of those who are currently uninsured will be eligible through this expansion. The influx of enrollees will bring new strengths and challenges to the Medicaid program. The federal government will finance 100% of the costs for new enrollees initially, and eventually these costs will be split with states.

Figure 14

Health Insurance Coverage and Federal Assistance Under the ACA for Uninsured Women, Ages 18 to 64



Note: Other includes programs such as Medicare and military-related coverage.
The federal poverty level for a family of three in 2010 was $18,310.
SOURCE: KFF/Urban Institute analysis of 2010 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

The ACA temporarily raises payment rates to primary care providers that accept Medicaid, recognizing that low reimbursement has been a major factor in provider participation and access for beneficiaries. However, there are still concerns about having a workforce large enough to care for the growing insured population.

In addition to expanding coverage, the ACA affects many other important areas of women's health for Medicaid beneficiaries. State Medicaid programs will receive a 1% increase in the federal matching rate if they cover, without cost sharing, preventive services that receive an A or B rating by the U.S. Preventive Services Task Force and immunizations that are recommended by the Federal Advisory Committee on Immunization Practices. This incentive, however, does not apply to the guidelines for women's preventive services issued by HHS for new private plans, which include lactation supports such

as breast pump rental, screening and counseling for intimate partner violence, and well woman visits.[26] As discussed earlier, Medicaid already covers contraceptives without cost-sharing and states receive a 90% federal match for those services.

While Medicaid already plays a large role in maternity care, the ACA requires Medicaid coverage of comprehensive tobacco cessation programs for pregnant women and increased support for nurse midwives, birth attendants, and free-standing birth centers. All new Medicaid beneficiaries will receive a benchmark package that covers the minimum level of benefits covered by plans in the new State Exchanges.

The ACA offers a number of opportunities to improve health care access and coverage for low-income women, with Medicaid as the foundation for coverage expansion. However, the many fiscal constraints the Medicaid program already faces at the federal and state levels will persist. Cuts to provider payments and limits on benefits and scope of coverage will have a disproportionate impact on women, as women comprise the majority of Medicaid beneficiaries at all ages. The Medicaid program continues to be a lifeline to care for millions of low-income women across the nation. The implementation of the ACA and the further expansion of Medicaid to insured low-income women will make this program even more vital in the years to come.

ENDNOTES

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This brief was prepared by Alina Salganicoff and Usha Ranji of the Kaiser Family Foundation.

Table 1:
State Level Estimates of Percent of Uninsured Women Ages 18-64 Who May Qualify for Medicaid in 2014 under the Affordable Care Act (ACA)

	Total Number of Women Ages 18-64 in State	Total Number of Uninsured Women 2009-2010	Percent of Total Women in State Who are Uninsured	Percent of Currently Uninsured Women Potentially Eligible for Medicaid in 2014*
Alabama	1,506,590	292,439	19%	65%
Alaska	216,047	42,826	20%	52%
Arizona	2,026,485	423,303	21%	61%
Arkansas	888,481	222,003	25%	55%
California	11,481,710	2,653,113	23%	56%
Colorado	1,612,440	255,314	16%	51%
Connecticut	1,124,941	136,910	12%	42%
Delaware	274,198	38,071	14%	46%
District of Columbia	217,877	26,476	12%	58%
Florida	5,672,685	1,483,193	26%	54%
Georgia	3,200,212	770,366	24%	58%
Hawaii	379,081	38,291	10%	60%
Idaho	466,253	105,558	23%	53%
Illinois	4,052,735	693,031	17%	55%
Indiana	1,952,551	350,747	18%	52%
Iowa	948,991	134,093	14%	53%
Kansas	849,827	133,162	16%	58%
Kentucky	1,381,758	257,470	19%	62%
Louisiana	1,414,428	339,714	24%	61%
Maine	425,272	48,713	11%	38%
Maryland	1,873,012	272,849	15%	52%
Massachusetts	2,130,804	109,172	5%	50%
Michigan	3,142,133	503,162	16%	59%
Minnesota	1,627,690	165,339	10%	44%
Mississippi	893,691	219,942	25%	62%
Missouri	1,869,155	334,166	18%	54%
Montana	299,524	62,408	21%	49%
Nebraska	557,220	82,523	15%	45%
Nevada	808,735	201,356	25%	55%
New Hampshire	434,284	55,027	13%	36%
New Jersey	2,733,276	476,014	17%	50%
New Mexico	612,565	154,740	25%	60%
New York	6,314,656	1,011,706	16%	49%
North Carolina	2,969,824	656,262	22%	59%
North Dakota	201,509	30,018	15%	49%
Ohio	3,653,603	613,893	17%	54%
Oklahoma	1,122,831	249,897	22%	53%
Oregon	1,228,515	236,963	19%	56%
Pennsylvania	3,926,418	521,023	13%	50%
Rhode Island	343,551	44,765	13%	49%
South Carolina	1,446,607	325,874	23%	57%
South Dakota	248,237	41,434	17%	52%
Tennessee	1,983,063	347,610	18%	55%
Texas	7,735,468	2,357,264	30%	58%
Utah	832,186	140,584	17%	48%
Vermont	210,937	21,398	10%	36%
Virginia	2,537,147	394,076	16%	45%
Washington	2,140,278	332,886	16%	52%
West Virginia	571,700	116,908	20%	59%
Wisconsin	1,717,613	173,587	10%	45%
Wyoming	166,649	36,729	22%	42%

Note: The federal poverty level (FPL) for a family of three in 2010 was $18,310. *Percent of women ages 18-64 who are currently uninsured with incomes ≤138% FPL. These estimates are based on income levels only and do not take into account citizenship status, which can affect eligibility.
Source: Kaiser Family Foundation/Urban Institute estimates of ASEC supplement to March 2010 and March 2011 Current Population Surveys, U.S. Census Bureau.

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The Henry J. Kaiser Family Foundation: 2400 Sand Hill Road, Menlo Park, CA 94025 (650) 854-9400 Facsimile: (650) 854-4800
Washington, D.C. Office: 1330 G Street, N.W., Washington, DC 20005 (202) 347-5270 Facsimile: (202) 347-5274 www.kff.org
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