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May 11, 2017

Medicaid Works for Women — But Proposed Cuts Would Have Harsh, Disproportionate Impact

By Hannah Katch, Jessica Schubel, and Matt Broaddus

Republican leaders in Congress and the White House have proposed to deeply cut Medicaid by effectively eliminating the Affordable Care Act's (ACA) Medicaid expansion, and breaking the federal government's decades-long guarantee to pay a set share of states' Medicaid costs. These cuts would have devastating consequences for millions of Americans, including the nearly 40 million women who rely on Medicaid. Women would bear a disproportionate share of the burden because they make up a majority (53 percent) of Medicaid beneficiaries, are the primary utilizers of family planning and maternity care benefits, and are much more likely to use Medicaid's long-term services and supports as they age. The Appendix tables at the end of this report provide state-specific data on Medicaid's significant role in women's health.

Medicaid Changes Have Expanded Women's Access to Care

Originally, most adult women weren't eligible for Medicaid: eligibility was limited almost exclusively to children, cash assistance recipients, seniors, and people with disabilities. Eligibility expansions in the 1980s and 1990s enabled many more low-income children, parents, and pregnant women in working families to qualify. Even with these changes, before the ACA, many low-income women were left out because they weren't in a population category eligible for the program.[1]

The ACA's Medicaid expansion changed that. In the 32 states that have expanded, women with incomes at or below 138 percent of the poverty line ($16,643 for a single person or $28,180 for a family of three in 2017) can enroll.

The Medicaid expansion gave women not raising children access to coverage and offered continuous coverage to new mothers who had qualified for Medicaid while pregnant but whose

[1] All states also offered limited coverage for uninsured women ineligible for Medicaid who have a diagnosis of breast or cervical cancer, however these programs do not offer consistent access to primary and preventive care, inpatient care, or long-term care services, see: Judith Solomon, "Medicaid Works: A Critical and Evolving Pillar of U.S. Health Care," Center on Budget and Policy Priorities, July 2016, http://www.cbpp.org/blog/medicaid-works-a-critical-and-evolving-pillar-of-us-health-care.

incomes were not low enough to qualify as a parent.[2] States that have yet to expand Medicaid have largely maintained Medicaid's narrow eligibility criteria, preventing many low-income women from enrolling in Medicaid until they become pregnant and ending their eligibility 60 days after the birth of their child.[3]

Medicaid Provides Essential Health Services to Women of All Ages

Medicaid allows women to obtain the health care they need throughout their lives. Women have unique health care needs — they are the primary users of maternity care, family planning, and long-term care services — and nearly half of all women have an ongoing condition requiring regular monitoring, care, or medication.[4] Moreover, women use many other health benefits differently from men, such as mental health and substance use disorder treatment.

Women of reproductive age rely especially on Medicaid's family planning and maternity care services. Medicaid covered 12.9 million women ages 15-44 in 2015 — 20 percent of all women in this age group and 48 percent of women in this age group with incomes below the poverty line.[5] Medicaid is also an essential support for women of color ages 15-44: 31 percent of African American women and 27 percent of Hispanic women in this age group are enrolled in Medicaid.[6]

Family Planning

Nearly all women use some form of family planning during their reproductive years, and Medicaid finances 75 percent of all publicly funded family planning services.[7] Family planning services are essential for women's health: almost half of all pregnancies are unintended, and unintended pregnancies are associated with negative health and economic consequences for families as well as increased spending for states and the federal government.[8]

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[2] Usha Ranji, Yali Bair, and Alina Salganicoff, "Medicaid and Family Planning: Background and Implications of the ACA," Kaiser Family Foundation, February 3, 2016, http://kff.org/report-section/medicaid-and-family-planning-medicaid-family-planning-policy/; prior to the Medicaid expansion, the median eligibility level for parents in 2013 was 61 percent; see Marcha Heberlein, Tricia Brooks, and Joan Alker, "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012–2013," Kaiser Family Foundation, January 2013.

[3] Kaiser Family Foundation, "Medicaid's Role for Women Across the Lifespan: Current Issues and the Impact of the Affordable Care Act," December 2012.

[4] Alina Salganicoff *et al.,* "Women and Health care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women's Health Survey," Kaiser Family Foundation, May 2014.

[5] Adam Sonfield, "Why Protecting Medicaid Means Protecting Sexual and Reproductive Health," *Guttmacher Policy Review*, March 2017.

[6] *Ibid.*

[7] *Op cit.,* Kaiser Family Foundation 2012; Kimberly Daniels, William Mosher, and Jo Jones, "Contraceptive Methods Women Have Ever Used: United States, 2982-2010," National Health Statistics Reports, February 2013, https://www.cdc.gov/nchs/data/nhsr/nhsr062.pdf.

[8] Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2020 Topics & Objectives: Family Planning, https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning.

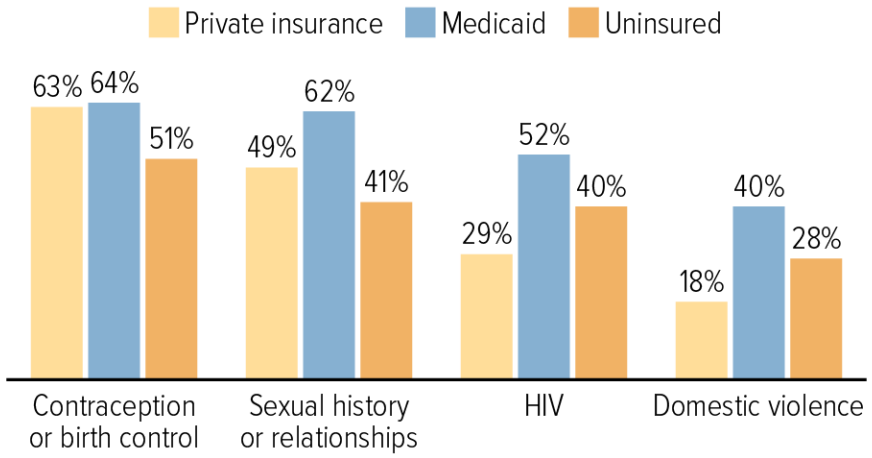
States must offer family planning services for women enrolled in Medicaid. The federal government funds 90 percent of the cost of these services — significantly higher than the 64 percent average federal match for most other Medicaid services. States have considerable flexibility deciding which family planning services to cover, but they generally cover contraceptive services and supplies, Pap smears, sexually transmitted disease testing, and counseling. These services are effective: in 2013, women with Medicaid coverage were more likely than women with private insurance to report they had spoken with a provider about sexual history, HIV, and intimate partner violence.[9] (See Figure 1.)

Medicaid's family planning services have no cost-sharing charges, and women have "freedom of choice" of family planning providers. This means they can receive family planning services and supplies from any willing and qualified Medicaid provider.[10]

FIGURE 1

Medicaid Provides Low-Income Women With Counseling on Sexual Health Topics

Share of women reporting their provider discussed these reproductive health issues with them in past 1-3 years, by insurance type



Note: Among women ages 15-44. For women 18+, have discussed within the past 3 years. For women ages 15-17, have discussed within past 12 months.

Source: Kaiser Family Foundation, 2013 Kaiser Women's Health Survey

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[9] *Op cit.,* Ranji 2016.

[10] States may not exclude providers due to criteria unrelated to their ability to provide family planning services, such as whether the provider also performs privately funded abortions (federal funds can't be used for abortion except in cases of danger to the life of the mother, rape, or incest). This guarantee has recently been upheld by several federal courts in light of recent state attempts to prohibit Medicaid funding for services provided at Planned Parenthood.

Texas Maternal Mortality Nearly Doubled After Family Planning Cuts

In 2011, the Texas legislature directed the state to prohibit organizations providing abortion from participating in the state's Medicaid family planning waiver, even though Medicaid doesn't cover abortion except in cases of rape or incest or danger to the woman's life. In 2012, the Centers for Medicare & Medicaid Services informed Texas that this prohibition deprived women of freedom of choice guaranteed by Medicaid law. Texas chose to end its federal family planning waiver rather than reverse the ban on providers that perform abortions. Although the state continues to provide limited funds for its family planning program, the number of family planning organizations receiving funds plummeted from 76 to 41 in two years,[a] and the use of long-acting, reversible contraceptives among Texas' Medicaid beneficiaries declined more than one-third between 2011 and 2014.[b]

Also, an analysis of maternal mortality in Texas showed a near doubling in the reported rate of maternal deaths from 2011 to 2012. While the study's authors didn't examine the causes of increased maternal mortality (which the World Health Organization defines as death of a woman while pregnant or within 42 days after pregnancy termination for causes related to the pregnancy), they cited access to women's health services as a possible factor.[c]

[a] Usha Ranji, Yali Bair, and Alina Salganicoff, "Medicaid and Family Planning: Background and Implications of the ACA," Kaiser Family Foundation, February 2016, http://kff.org/report-section/medicaid-and-family-planning-the-aca-medicaid-expansion-and-family-planning/.

[b] Amanda J. Stevenson *et al.,* "Effect of Removal of Planned Parenthood from the Texas Women's Health Program," *The New England Journal of Medicine,* February 2016.

[c] Marian MacDorman *et al.,* "Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues," *Obstetrics & Gynecology*, September 2016, http://d279m997dpfwgl.cloudfront.net/wp/2016/08/MacDormanM.USMatMort.OBGYN_.2016.online.pdf

Over 20 years ago, states began using Medicaid waivers (technically known as section 1115 demonstration authority) to expand access to family planning services to women who would otherwise not qualify for Medicaid. These waivers provide family planning-related coverage to women with incomes above the state's Medicaid limit, including those who lost Medicaid eligibility after having a baby. Before the ACA, 28 states used these waivers to provide family planning services to women.[11] More than half of states have used this authority to establish permanent family planning programs for people who would not otherwise qualify for Medicaid. Recognizing the success of these programs, the ACA allows states to permanently adopt their family planning programs as a state option without a waiver.[12]

Maternity Care

Medicaid provides health care for nearly half of all pregnant women, supporting them through their pregnancies and ensuring that their babies have a healthy start.[13] Medicaid has historically required states to cover pregnant women at much higher eligibility levels than other adults. All states must cover pregnant women up to 133 percent of poverty, and 34 states cover pregnant women with family incomes above 200 percent of poverty as of January 2017. Eligibility at these higher income thresholds extends through pregnancy and the 60 days after childbirth.[14]

[11] *Op cit.,* Ranji 2016.

[12] *Ibid.*

[13] *Op cit.,* Solomon 2016.

[14] *Op cit.,* Ranji 2016.

The Medicaid expansion, by enabling states to bring other adults up to 138 percent of poverty without a federal waiver, has allowed many women to maintain continuous access to primary care and family planning services before and after pregnancy, and to avoid unintended pregnancy. When women have health coverage before becoming pregnant as well as between pregnancies, they are healthier during pregnancy and their babies are more likely to be healthy at birth, research shows. Between the birth of one child and the conception of another, health coverage gives women access to care that can improve the outcomes of subsequent pregnancies. This can include treatment for diabetes and hypertension; clinical interventions focused on combating family violence, depression, and stress; and other forms of parental support.[15]

States' coverage of pre- and post-natal services varies significantly. Most states cover prenatal vitamins, ultrasounds, and prenatal testing such as amniocentesis, as well as substance use disorder treatment services for pregnant and postpartum women. Some states also offer education services to support childbirth, infant care, and parenting and to help women initiate and maintain breastfeeding, including breast pumps and lactation counseling.[16]

Infants born to women on Medicaid are automatically enrolled in the program until their first birthday.[17] This immediate and uninterrupted coverage is essential: research shows that people who had Medicaid during early childhood have better long-term health and achievement in adulthood than those who were uninsured.[18]

Medicaid can also play an important role in identifying children whose mothers experience depression and connecting mothers and children to the help they need. Guidance that the Centers for Medicare & Medicaid Services (CMS) released in 2016 cites evidence showing that between 5 and 25 percent of all pregnant, postpartum, and parenting women have some type of depression; for mothers with low incomes, rates of depressive symptoms are between 40 and 60 percent. More than half of infants living in poverty are being raised by mothers with some form of depression.[19]

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[15] Michael C. Lu, *et al.*, "Preconception Care Between Pregnancies: The Content of Internatal Care," Maternal and Child Health Journal, July 2006; Center on Budget and Policy Priorities, "Expanding Medicaid Will Benefit Both Low-Income Women and Their Babies," April 2013, http://www.cbpp.org/sites/default/files/atoms/files/Fact-Sheet-Impact-on-Women.pdf.

[16] Kathy Gifford *et al.,* "Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey," Kaiser Family Foundation, April 2017.

[17] States must evaluate the eligibility for newborns before their first birthday to ensure they stay covered if they remain eligible.

[18] Edwin Park *et al.,* "Frequently Asked Questions About Medicaid," Center on Budget and Policy Priorities, updated March 29, 2017, http://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid.

[19] Centers for Medicare & Medicaid Services, "Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children," May 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf.

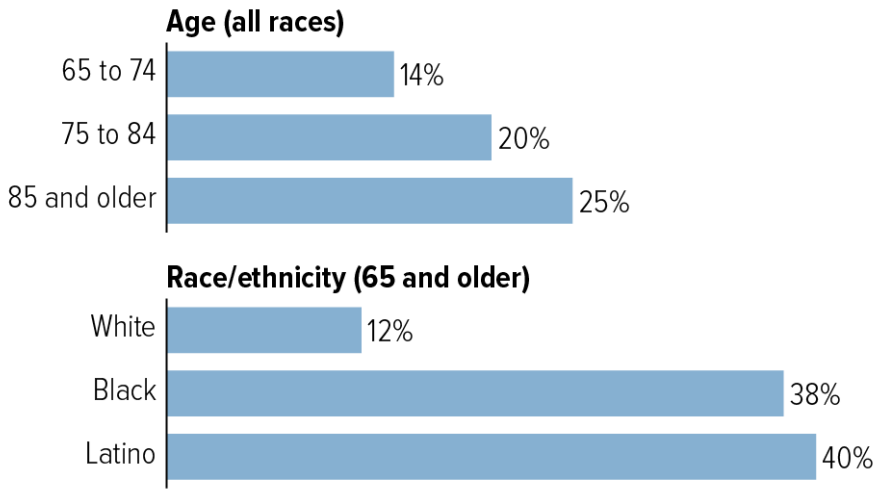
The guidance clarifies that states can include screening mothers for maternal depression as part of well-child visits even if the mother isn't enrolled in Medicaid, because of evidence that maternal depression can place children at risk of adverse health consequences.[20]

Long-Term Care

Medicaid helps women as they age, even when they become eligible for Medicare. Women live longer than men and are significantly more likely to need long-term care services through Medicaid. Sixty-nine percent of the 9 million dually eligible beneficiaries — people covered by both Medicare and Medicaid — are women. "Duals" are typically over 65 years of age or younger low-income individuals with disabilities who have significant health care needs. Medicaid plays an especially critical role for older women of color, covering nearly 40 percent of Latina and African American women over 65 who are also enrolled in Medicare.[21] (See Figure 2.)

FIGURE 2

Significant Shares of Older Women on Medicare Also Receive Medicaid



Note: Analysis of Medicare beneficiaries 65 and older.

Source: Kaiser Family Foundation analysis of Centers for Medicare & Medicaid Services Medicare current beneficiary survey 2009 cost and use file

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[20] *Ibid.*

[21] Kaiser Family Foundation, "Medicare's Role for Women," May 16, 2013, http://kff.org/womens-health-policy/fact-sheet/medicares-role-for-older-women/.

Medicaid pays for half of the nation's long-term services and supports,[22] and women make up seven in ten nursing home residents and over two-thirds of people receiving home and community based care.[23] Medicaid offers these services and supports in institutional settings like nursing homes as well as care in people's homes, usually referred to as home- and community-based services (HCBS). HCBS include case management, home health aides, personal attendant services to help with daily living activities such as bathing and dressing, and adult day health.

Enormous progress has been made over the decades to increase access to care in home- and community-based settings, which are less expensive and where many seniors and people with disabilities prefer to live. In 2013, for the first time in the program's history, Medicaid spent more on home- and community-based care than on institutional care.[24]

Treatment for Substance Use Disorders

The Affordable Care Act's Medicaid expansion, coupled with the Mental Health Parity and Addiction Equity Act of 2008, have dramatically improved access to treatment for people with substance use disorders. Improved access is essential in addressing these disorders, which have received greater attention due to the opioid epidemic.

Prescription painkiller overdoses have increased precipitously in recent years and are a growing problem among women: more than five times as many women died from opioid overdoses in 2010 as in 1999 (6,631 versus 1,287). About 42 women die every day from substance use overdoses, including opioid overdoses. More than 200,000 women visited the emergency department for opioid-related conditions, or statistically one every three minutes.[a]

Women are more likely than men to report chronic pain and to be prescribed prescription painkillers; they also are given higher doses and use them for longer periods of time than men.[b]

Hundreds of thousands of people with substance use disorders have gained Medicaid coverage through the Medicaid expansion. This has had dramatic results. In states that expanded Medicaid, the share of people with substance use or mental health disorders who were hospitalized but uninsured fell from about 20 percent in 2013 to 5 percent by mid-2015.

[a] Centers for Disease Control and Prevention, "Prescription Painkiller Epidemic Among Women," https://www.cdc.gov/media/dpk/prescription-drug-overdose/prescription-painkiller-epidemic/index.html.

[b] Centers for Disease Control and Prevention, "Prescription Painkiller Overdoses," https://www.cdc.gov/vitalsigns/prescriptionpainkilleroverdoses/index.html.

Medicaid Cuts Would Disproportionately Harm Women

The House Republican bill to repeal the ACA, the American Health Care Act (which passed the House on May 4), would radically restructure and deeply cut Medicaid, reducing enrollment by 14 million people by 2026. While the cuts would jeopardize care for all Medicaid beneficiaries, they

[22] Centers for Medicare & Medicaid Services, "Medicaid and CHIP: Strengthening Coverage, Improving Health," January 2017, https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf.

[23] *Op cit.,* Kaiser 2012.

[24] *Op cit.,* Centers for Medicare & Medicaid Services 2017.

would disproportionately affect women due to the higher proportion of women who rely on Medicaid and the specific services at risk of cuts.

The bill would cut $839 billion in federal spending from Medicaid over ten years by effectively eliminating the Medicaid expansion and permanently capping annual funding for states, regardless of the cost of services for their Medicaid beneficiaries.[25]

The legislation also specifically targets access to women's health care services by barring states from reimbursing Planned Parenthood for its preventive health and family planning services for women and men enrolled in Medicaid. This would cause thousands of low-income women to lose access to care and raise state and federal Medicaid costs related to unplanned pregnancies. Fifteen percent of women on Medicaid who rely on Planned Parenthood for family planning services would lose access to those services, the Congressional Budget Office estimates.[26]

The bill also permits states to impose work requirements on Medicaid beneficiaries, which would penalize those least able to get and hold a job while keeping others from improving their health and participating in the workforce. Almost two-thirds of the 11 million beneficiaries who risk losing coverage from a work requirement are women.[27] Many of these are women with a disability or chronic health condition or who are caring for a family member. Many others have low-wage jobs that don't offer health coverage.

The Republican bill isn't the only threat to women's health coverage. Health and Human Services Secretary Tom Price, and CMS Administrator Seema Verma recently notified governors that the Trump Administration will give states greater flexibility to limit access to Medicaid enrollment and access to care.[28] CMS could allow states to waive many legal requirements and consumer protections that could disproportionately affect women and their access to coverage, including family planning services. These waivers would be a sharp departure from the family planning waivers discussed above, which enabled states to *expand* access to coverage.

Several states are considering seeking waivers to impose premiums and cost-sharing as a condition of Medicaid eligibility for people in poverty, which would limit access to care for many women.[29] States are also considering drug-testing Medicaid beneficiaries, setting time limits on Medicaid benefits, and requiring people to work or search for work in order to maintain their benefits. These proposals fail to advance Medicaid's core objective of delivering health care to vulnerable

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[25] Edwin Park, Judith Solomon, and Hannah Katch, "Updated House ACA Repeal Bill Deepens Damaging Medicaid Cuts for Low-Income Individuals and Families," Center on Budget and Policy Priorities, March 21, 2017, http://www.cbpp.org/research/health/updated-house-aca-repeal-bill-deepens-damaging-medicaid-cuts-for-low-income.

[26] Congressional Budget Office, "Cost Estimate: American Health Care Act," March 2017, https://www.cbo.gov/publication/52486.

[27] Leighton Ku and Erin Brantley, "Medicaid Work Requirements: Who's At Risk?" Health Affairs, April 2017.

[28] Centers for Medicare & Medicaid Services, letter to governors, March 2017, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf.

[29] Jessica Schubel and Judith Solomon, "States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility," Center on Budget and Policy Priorities, April 9, 2015, http://www.cbpp.org/research/health/states-can-improve-health-outcomes-and-lower-costs-in-medicaid-using-existing.

populations who can't otherwise afford it, as federal law requires of Medicaid waivers, and they would significantly restrict access to care for millions of women who rely on Medicaid as an essential support.

House Bill Would Also Harm Women with Private Insurance

The House bill also includes several provisions that are especially harmful to women with private insurance. For example, it would allow states to opt out of the ACA's Essential Health Benefits (EHB) standard, leaving many women without affordable access — or any access — to maternity coverage. (Before the ACA, nearly two-thirds of people in the individual market had plans that lacked maternity coverage.[a]) The bill also would give states the option of allowing insurers to base premiums on people's health status and medical history; insurers could charge far higher premiums to people who are pregnant, have had a c-section, take fertility drugs, were treated for injuries resulting from domestic violence, or have experienced irregular monthly periods.[b]

Moreover, allowing states to weaken or eliminate the EHB standard could effectively eliminate protections against high out-of-pocket costs for people with employer coverage. Women could once again face annual and lifetime caps on the amount their employer plans will pay out in benefits for particular services such as maternity care, or they might find their plans no longer cap the amount enrollees must pay each year for certain covered items and services.[c]

[a] Sarah Lueck, "If 'Essential Health Benefits' Standards Are Repealed, Health Plans Would Cover Little," Center on Budget and Policy Priorities, March 23, 2017.

[b] National Partnership for Women and Families, "Why the Affordable Care Act Matters for Women: Summary of Key Provisions," September 2015.

[c] Matthew Fiedler, "Allowing states to define "essential health benefits" could weaken ACA protections against catastrophic costs for people with employer coverage nationwide," Brookings Institution, May 2017; Gary Claxton *et al.*, "Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA," Kaiser Family Foundation, December 2016.

TABLE 1

Women and Girls Below the Poverty Line

State	Women and girls in poverty	Share of all women and girls in poverty
United States	25,553,670	16.0%
Alabama	494,820	20.2%
Alaska	38,590	11.2%
Arizona	627,260	18.5%
Arkansas	301,940	20.4%
California	3,186,480	16.4%
Colorado	330,000	12.3%
Connecticut	203,210	11.4%
Delaware	64,490	13.5%
District of Columbia	61,620	18.4%
Florida	1,721,750	16.8%
Georgia	960,060	18.7%
Hawaii	77,380	11.1%
Idaho	131,350	16.1%
Illinois	948,920	14.8%
Indiana	529,430	16.2%
Iowa	204,320	13.4%
Kansas	198,710	13.9%
Kentucky	443,290	20.2%
Louisiana	512,190	21.8%
Maine	94,660	14.3%
Maryland	330,940	10.9%
Massachusetts	424,880	12.6%
Michigan	844,630	17.1%
Minnesota	298,900	11.1%
Mississippi	361,100	23.9%
Missouri	492,310	16.3%
Montana	77,810	15.5%
Nebraska	129,960	14.0%
Nevada	223,690	15.6%
New Hampshire	60,260	9.2%
New Jersey	529,350	11.7%
New Mexico	218,390	21.1%
New York	1,663,960	16.7%
North Carolina	898,200	17.8%
North Dakota	43,500	12.2%
Ohio	933,270	16.1%

TABLE 1

Women and Girls Below the Poverty Line

State	Women and girls in poverty	Share of all women and girls in poverty
Oklahoma	338,690	17.6%
Oregon	328,570	16.4%
Pennsylvania	910,140	14.3%
Rhode Island	78,900	15.1%
South Carolina	445,210	18.1%
South Dakota	63,660	15.4%
Tennessee	594,620	17.9%
Texas	2,354,740	17.3%
Utah	178,950	12.2%
Vermont	34,000	11.1%
Virginia	513,610	12.3%
Washington	462,810	13.1%
West Virginia	179,800	19.7%
Wisconsin	372,470	13.1%
Wyoming	35,890	12.6%

Source: American Community Survey, 2015

TABLE 2

More Than 40 Million Women and Girls Are Enrolled in Medicaid

State	Female Medicaid Enrollees	Female Medicaid Enrollees as Share of Medicaid Population	Females as Share of Total Population
United States	40,412,400	53.9%	50.8%
Alabama	491,300	55.0%	51.6%
Alaska	90,400	51.1%	47.3%
Arizona	920,000	52.9%	50.4%
Arkansas	507,400	53.5%	51.0%
California	6,584,400	53.1%	50.4%
Colorado	735,100	53.0%	49.7%
Connecticut	413,000	54.3%	51.2%
Delaware	133,200	55.1%	51.9%
District of Columbia	150,000	56.6%	52.3%
Florida	2,348,900	54.2%	51.2%
Georgia	968,300	55.2%	51.3%
Hawaii	181,100	52.3%	49.6%
Idaho	156,900	52.3%	50.0%
Illinois	1,679,700	54.8%	51.0%
Indiana	824,000	54.6%	50.8%
Iowa	339,700	54.6%	50.4%
Kansas	209,300	51.2%	50.2%
Kentucky	666,000	54.1%	50.8%
Louisiana	766,400	54.1%	51.0%
Maine	143,900	53.4%	50.9%
Maryland	704,000	54.9%	51.7%
Massachusetts	890,300	53.8%	51.4%
Michigan	1,229,200	52.8%	50.9%
Minnesota	554,600	52.8%	50.3%
Mississippi	377,600	55.2%	51.6%
Missouri	537,300	55.0%	51.0%
Montana	129,200	52.7%	49.7%
Nebraska	137,400	56.4%	50.3%
Nevada	330,300	53.0%	50.0%
New Hampshire	98,600	51.5%	50.4%
New Jersey	972,000	54.1%	51.1%
New Mexico	418,300	54.0%	50.3%
New York	3,470,600	54.1%	51.4%
North Carolina	1,128,100	54.1%	51.3%
North Dakota	51,600	54.5%	48.7%

TABLE 2

More Than 40 Million Women and Girls Are Enrolled in Medicaid

State	Female Medicaid Enrollees	Female Medicaid Enrollees as Share of Medicaid Population	Females as Share of Total Population
Ohio	1,610,100	55.3%	51.0%
Oklahoma	426,900	53.1%	50.5%
Oregon	523,200	53.1%	50.6%
Pennsylvania	1,611,900	55.2%	51.1%
Rhode Island	162,500	54.5%	51.6%
South Carolina	553,000	55.5%	51.3%
South Dakota	65,400	54.5%	49.7%
Tennessee	901,000	55.0%	51.3%
Texas	2,556,800	53.3%	50.4%
Utah	159,500	51.3%	49.6%
Vermont	87,600	51.8%	50.5%
Virginia	544,500	54.8%	50.9%
Washington	957,600	52.7%	50.0%
West Virginia	312,900	55.2%	50.7%
Wisconsin	554,200	53.4%	50.3%
Wyoming	32,600	52.7%	50.0%

Source: American Community Survey, 2015 and Centers for Medicare and Medicaid Services, 2016 (https://www.medicaid.gov/medicaid/program-information/downloads/updated-december-2016-enrollment-data.pdf)

Method: ACS data are used to estimate the share of Medicaid enrollees in each state that are female. Then, these estimates are applied to the most recent available Medicaid administrative enrollment figures from CMS.

TABLE 3

Race and Ethnicity of Women and Girls Enrolled in Medicaid

State	Total	White	African-American	Asian/ Pacific Islander	Hispanic	Other	% White	% African-American	% Asian/ Pacific Islander	% Hispanic	% Other
United States	40,412,400	17,497,800	8,158,700	1,845,700	11,046,500	1,863,600	43%	20%	5%	27%	5%
Alabama	491,300	227,900	215,500	3,300	30,000	14,700	46%	44%	1%	6%	3%
Alaska	90,400	39,100	6,600	6,700	4,100	33,800	43%	7%	7%	5%	37%
Arizona	920,000	326,300	53,900	17,200	429,700	92,900	35%	6%	2%	47%	10%
Arkansas	507,400	314,900	126,600	5,200	38,900	21,800	62%	25%	1%	8%	4%
California	6,584,400	1,476,200	495,300	734,700	3,635,100	243,200	22%	8%	11%	55%	4%
Colorado	735,100	359,500	52,700	19,800	274,100	29,000	49%	7%	3%	37%	4%
Connecticut	413,000	186,300	73,300	9,400	130,800	13,200	45%	18%	2%	32%	3%
Delaware	133,200	57,900	46,800	2,300	19,200	7,000	43%	35%	2%	14%	5%
District of Columbia	150,000	4,600	126,300	1,300	14,400	3,400	3%	84%	1%	10%	2%
Florida	2,348,900	875,500	592,400	35,300	775,000	70,800	37%	25%	2%	33%	3%
Georgia	968,300	357,800	451,100	21,100	109,700	28,500	37%	47%	2%	11%	3%
Hawaii	181,100	23,900	1,300	52,000	29,600	74,300	13%	1%	29%	16%	41%
Idaho	156,900	113,400	300	400	31,900	10,900	72%	0%	0%	20%	7%
Illinois	1,679,700	655,900	475,500	61,100	443,100	44,000	39%	28%	4%	26%	3%
Indiana	824,000	540,300	153,700	13,300	83,400	33,400	66%	19%	2%	10%	4%
Iowa	339,700	257,800	22,400	6,300	34,500	18,700	76%	7%	2%	10%	6%
Kansas	209,300	120,900	23,500	5,400	45,700	13,800	58%	11%	3%	22%	7%
Kentucky	666,000	535,900	80,500	5,900	24,600	19,100	80%	12%	1%	4%	3%
Louisiana	766,400	297,500	398,000	9,300	36,500	25,000	39%	52%	1%	5%	3%
Maine	143,900	130,100	3,500	1,500	2,700	6,200	90%	2%	1%	2%	4%
Maryland	704,000	237,800	308,300	31,100	96,100	30,600	34%	44%	4%	14%	4%
Massachusetts	890,300	463,100	112,600	57,900	223,800	33,000	52%	13%	7%	25%	4%

TABLE 3

Race and Ethnicity of Women and Girls Enrolled in Medicaid

State	Total	White	African-American	Asian/ Pacific Islander	Hispanic	Other	% White	% African-American	% Asian/ Pacific Islander	% Hispanic	% Other
Michigan	1,229,200	727,300	335,600	23,600	90,100	52,600	59%	27%	2%	7%	4%
Minnesota	554,600	345,200	92,500	35,100	52,100	29,800	62%	17%	6%	9%	5%
Mississippi	377,600	141,900	216,100	1,800	10,300	7,500	38%	57%	0%	3%	2%
Missouri	537,300	350,200	130,400	3,800	29,400	23,500	65%	24%	1%	5%	4%
Montana	129,200	98,100	200	900	6,200	23,800	76%	0%	1%	5%	18%
Nebraska	137,400	76,800	18,100	3,000	30,000	9,400	56%	13%	2%	22%	7%
Nevada	330,300	124,100	47,900	18,300	116,400	23,800	38%	15%	6%	35%	7%
New Hampshire	98,600	83,900	2,000	1,500	7,200	3,900	85%	2%	2%	7%	4%
New Jersey	972,000	335,600	204,100	65,600	339,100	27,600	35%	21%	7%	35%	3%
New Mexico	418,300	99,300	6,400	4,200	245,100	63,300	24%	2%	1%	59%	15%
New York	3,470,600	1,229,000	711,900	344,500	1,072,600	112,600	35%	21%	10%	31%	3%
North Carolina	1,128,100	501,700	395,000	14,200	158,900	58,200	44%	35%	1%	14%	5%
North Dakota	51,600	36,000	2,100	600	1,300	11,600	70%	4%	1%	3%	22%
Ohio	1,610,100	1,016,900	400,000	21,500	93,100	78,600	63%	25%	1%	6%	5%
Oklahoma	426,900	234,200	35,100	5,600	62,600	89,400	55%	8%	1%	15%	21%
Oregon	523,200	347,800	18,000	17,900	105,600	34,000	66%	3%	3%	20%	6%
Pennsylvania	1,611,900	923,000	339,000	49,500	234,700	65,700	57%	21%	3%	15%	4%
Rhode Island	162,500	86,000	14,600	5,700	45,600	10,600	53%	9%	4%	28%	7%
South Carolina	553,000	241,400	251,500	4,500	32,000	23,600	44%	45%	1%	6%	4%
South Dakota	65,400	41,500	1,400	500	3,100	18,900	63%	2%	1%	5%	29%
Tennessee	901,000	544,000	248,800	7,200	63,400	37,700	60%	28%	1%	7%	4%
Texas	2,556,800	599,900	422,700	65,000	1,414,800	54,400	23%	17%	3%	55%	2%
Utah	159,500	108,600	2,600	3,500	35,800	9,100	68%	2%	2%	22%	6%
Vermont	87,600	79,500	1,000	2,600	1,700	2,800	91%	1%	3%	2%	3%

TABLE 3

Race and Ethnicity of Women and Girls Enrolled in Medicaid

State	Total	White	African-American	Asian/ Pacific Islander	Hispanic	Other	% White	% African-American	% Asian/ Pacific Islander	% Hispanic	% Other
Virginia	544,500	242,200	189,900	20,500	67,800	24,200	44%	35%	4%	12%	4%
Washington	957,600	549,200	52,400	61,200	206,000	88,800	57%	5%	6%	22%	9%
West Virginia	312,900	283,100	15,400	900	6,800	6,700	90%	5%	0%	2%	2%
Wisconsin	554,200	343,600	96,800	18,800	67,800	27,100	62%	17%	3%	12%	5%
Wyoming	32,600	24,000	600	100	5,200	2,800	74%	2%	0%	16%	9%

Source: American Community Survey 2015 and Centers for Medicare and Medicaid Services, 2016 (https://www.medicaid.gov/medicaid/program-information/downloads/updated-december-2016-enrollment-data.pdf)

Method: ACS data are used to estimate the share of Medicaid enrollees in each state that are female and the race and ethnicity of these female Medicaid enrollees. Then, these estimates are applied to the most recent available Medicaid administrative enrollment figures from CMS. Note, percentages may not add to 100 percent due to rounding.

TABLE 4

Share of Total Births Financed by Medicaid, 2010

State	Percent
United States	45%
Alabama	53%
Alaska	53%
Arizona	53%
Arkansas	67%
California	48%
Colorado	37%
Connecticut	31%
Delaware	N/A
District of Columbia	68%
Florida	49%
Georgia	42%
Hawaii	24%
Idaho	39%
Illinois	52%
Indiana	47%
Iowa	40%
Kansas	33%
Kentucky	44%
Louisiana	69%
Maine	63%
Maryland	26%
Massachusetts	27%
Michigan	45%
Minnesota	44%
Mississippi	65%
Missouri	42%
Montana	35%
Nebraska	31%
Nevada	44%
New Hampshire	30%
New Jersey	28%
New Mexico	53%
New York	46%
North Carolina	54%
North Dakota	29%
Ohio	38%
Oklahoma	64%

TABLE 4

Share of Total Births Financed by Medicaid, 2010

State	Percent
Oregon	45%
Pennsylvania	33%
Rhode Island	46%
South Carolina	50%
South Dakota	36%
Tennessee	51%
Texas	48%
Utah	31%
Vermont	47%
Virginia	30%
Washington	39%
West Virginia	52%
Wisconsin	50%
Wyoming	38%

Source: Anne Markus *et al*., "Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform," George Washington University School of Public Health and Health Services, October 2016, http://www.whijournal.com/article/S1049-3867(13)00055-8/pdf.