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 poor and low-income people, provided more than 22.4 million low-income women with basic health and long-term care coverage in 2009.[1] 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, including the implications of the 2012 Supreme Court decision, and the impact on women.

ELIGIBILITY POLICY

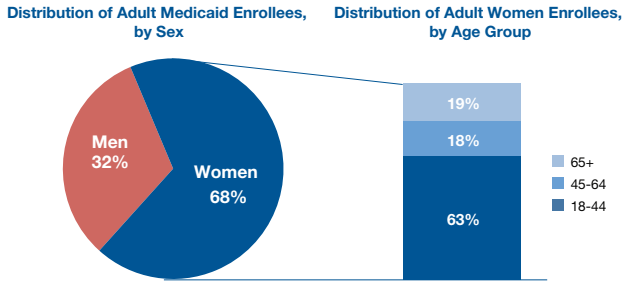
For a woman to qualify for Medicaid, she must meet both categorical and income criteria. That means she must fit into a certain "category," such as being pregnant, a mother of a child under age 18, a senior citizen, or having a disability. Each of these categorical groups has different income eligibility 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.

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. The ACA provides federal funds for states to expand eligibility to all individuals below 138% of poverty, effectively eliminating the categorical requirements that have limited eligibility to poor women who were pregnant, disabled, or mothers of dependent children.

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.[2]

Figure 1

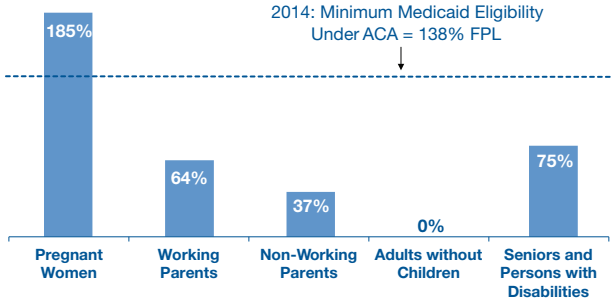
Adult Medicaid Enrollees, by Sex and Age Group, 2009



Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2009 MSIS.

Figure 2

Median Medicaid/CHIP Income Eligibility Thresholds for Adults, 2012



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 (FPL) is $19,090 for a family of three in 2012.
Source: KCMU and Georgetown University analysis, 2012.

[i] The federal poverty level (FPL) is $19,090 for a family of three in 2012. http://aspe.hhs.gov/poverty/12poverty.shtml

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, which was replaced by the Temporary Assistance for Needy Families (TANF) program in 1996. On average, income eligibility is 63% 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 2012, income eligibility levels for working parents ranged from 17% FPL in Arkansas to 215% FPL in Minnesota.[3]

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 other Medicaid 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, effectively becoming impoverished. 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.[4] 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 states will be able to extend Medicaid to many currently uninsured citizens and legal residents with incomes up to 138% FPL,[ii] *without* categorical requirements, and receive full federal funding for this new group. It is estimated that millions of women who are currently uninsured will qualify for Medicaid at that time, and this will vary greatly across states, depending on current policies and whether states choose to expand their Medicaid programs.[5]

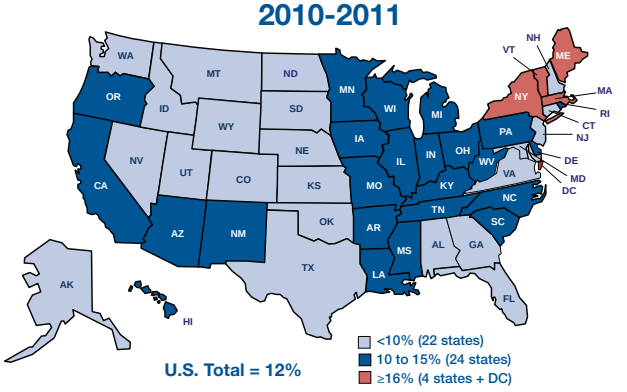
PROFILE OF WOMEN ON MEDICAID

In 2009, according to federal Medicaid enrollment data, 68% of adults (age 18 and older) on Medicaid were women and 32% were men.[6] 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 compared to the general population (Figure 4). More than half (57%) of non-elderly, adult women on Medicaid who live in the community have family incomes below the poverty level. One quarter (28%) of non-elderly women on Medicaid are very poor, with incomes below 50% of the poverty level, about $9,155 per year for a family of three.

One in four (26%) non-elderly women covered by Medicaid has not completed high school, and only 9% have a college degree or higher education level. Three in ten (31%) nonelderly women on Medicaid report fair or poor health, compared to 7% of women with private employer-sponsored coverage and 13% of women who are uninsured.[7]

Figure 3

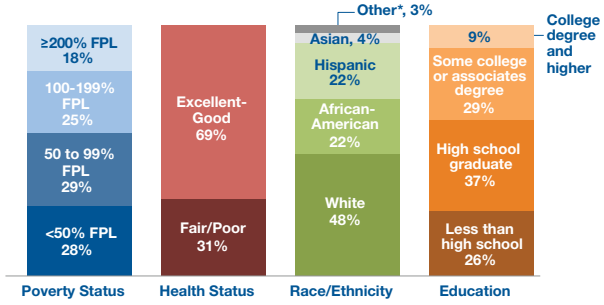
Share of Adult Women Covered by Medicaid, 2010-2011



Note: Includes women 18 to 64.
Source: Kaiser Family Foundation analysis of Urban Institute estimates based on March 2012 Current Population Survey, Census Bureau.

Figure 4

Profile of Non-Elderly Women on Medicaid, 2011



Note: Includes women on Medicaid ages 18 to 64. The federal poverty level was $18,530 for a family of three in 2011.
*Other consists of American Indian/Alaska Native, Pacific Islander, and two or more races.
Source: Kaiser Family Foundation analysis of Urban Institute estimates based on March 2012 Current Population Survey, Census Bureau.

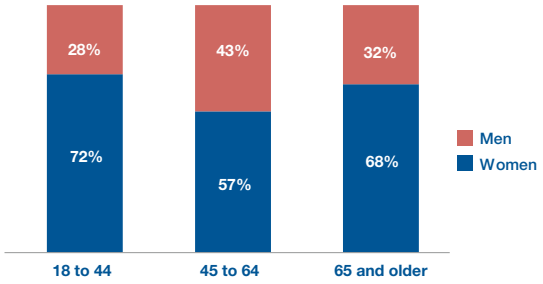
[ii] The level in the ACA statute is 133% of the Federal Poverty Level but there is a 5% income disregard that makes the effective expansion level 138% of the FPL.

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.

Figure 5

Gender Distribution of Adults Enrolled in Medicaid, by Age Group, 2009



Note: Includes women on Medicaid ages 18 and older.
Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2009 MSIS.

Reproductive Years

Nearly three-quarters (72%) of adult women on Medicaid are in their reproductive years (18 to 44), with some variation by state (Table 1 – see back page). 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 75% of all public expenditures.[8] 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."[9] 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.[10]

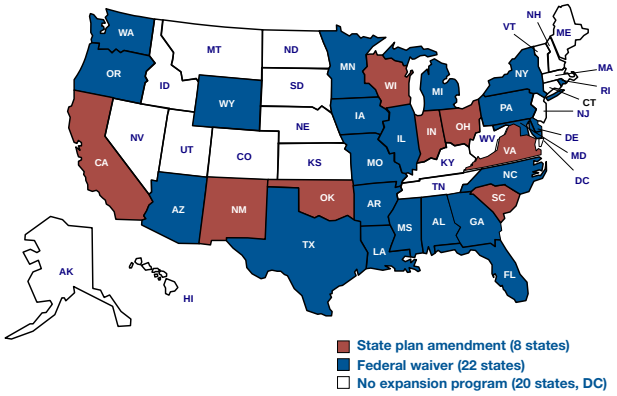
States can impose "nominal" cost sharing for most services under Medicaid, however family planning services and supplies are exempt. This means women cannot be charged any out-of-pocket costs for these services. The federal government also guarantees "freedom of choice" for Medicaid beneficiaries, which allows them to obtain family planning services from any provider that participates in the program. This guarantee has been upheld in recent federal court rulings over state attempts to restrict Medicaid funds to pay for services at Planned Parenthood clinics.

In recent years, 28 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 and abortions in several states.[12]

Until 2010, states had to obtain special permission (waiver) from the federal Medicaid rules to establish these programs since they offer more limited benefits, 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 allows them to change their Medicaid programs permanently without reapplying for federal permission. As of November 2012, at least eight states (CA, IN, NM, OH, OK, SC, VA, WI) have expanded family planning coverage through SPAs (Figure 6).[13]

Figure 6

Medicaid Family Planning Programs, 2012

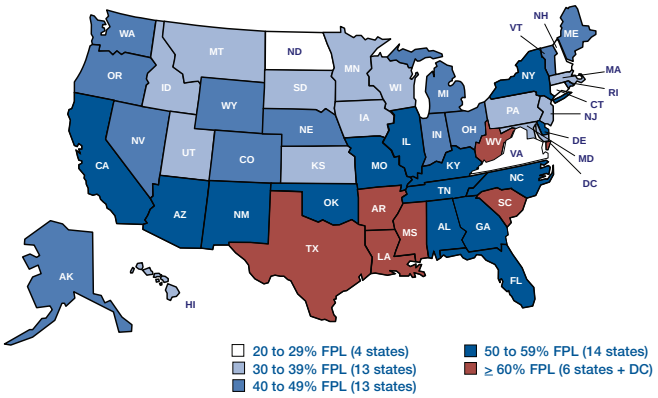


Source: Guttmacher Institute, *Medicaid Family Planning Eligibility Expansions, State Policies in Brief*, November 2012.

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).[14,15]

Figure 7

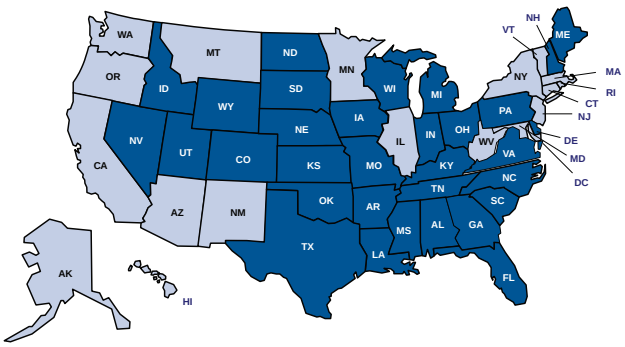
Share of Births Covered by Medicaid, 2006



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.

Figure 9

Abortion Financing Under Medicaid, 2012



Source: Guttmacher Institute, *State Funding of Abortion Under Medicaid, State Policies in Brief*, November 2012.

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.[16] In most states, Medicaid pays for prenatal visits and supplies such as prenatal vitamins, ultrasound and amniocentesis screenings, smoking cessation, and delivery services, including vaginal and cesarean deliveries.[17] 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.[18]

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 2012, 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.

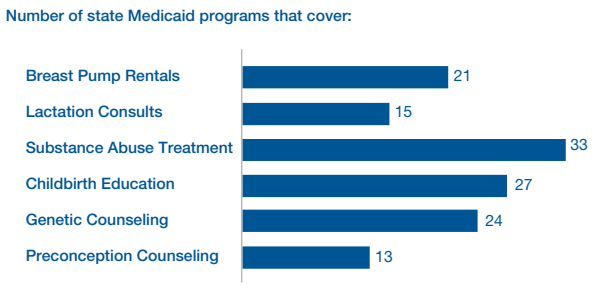
Mid-life Years

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,

Figure 8

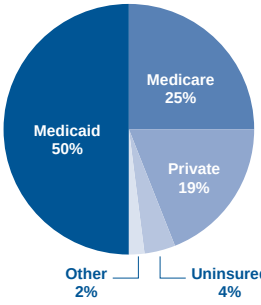
State Medicaid Coverage of Prenatal Services, 2009



Source: Kaiser Family Foundation, *State Medicaid Coverage of Perinatal Services: Summary of State Survey Findings*, 2009.

Figure 10

Health Coverage of Non-Elderly Women with Disabilities Living in the Community, 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.

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.

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.[19]

Seniors

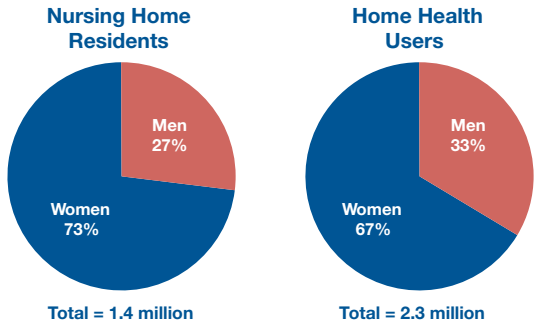
"Dual Eligible" Beneficiaries: While most seniors have coverage through Medicare, some people have both Medicare and Medicaid coverage, and are referred to as "dual eligible" beneficiaries. Dual eligible beneficiaries typically qualify for both programs because they are seniors or younger persons with 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 69% of this group.[20]

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 $87,000 annually —and have devastating economic consequences for women on fixed incomes.[21]

Figure 11

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



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

Medicaid finances 40% of long-term care expenditures[22], 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 services includes nursing home stays, as well as community-based supports, but the exact scope and level of coverage varies greatly between states.

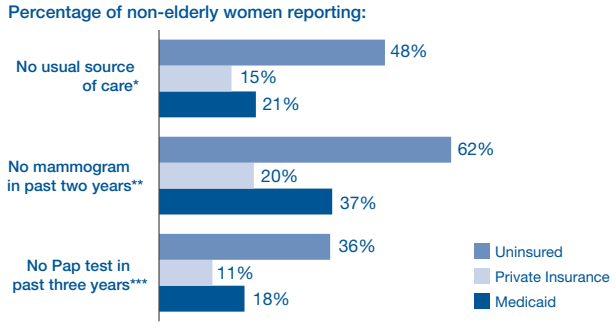
ACCESS TO CARE

Medicaid has been shown to improve access to care for low-income women. Compared to their uninsured counterparts, women with public coverage experience fewer barriers to care and on several measures have utilization rates comparable to women with private insurance (Figure 12).[23]

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

Figure 12

Women's Access Barriers by Insurance Coverage, 2010

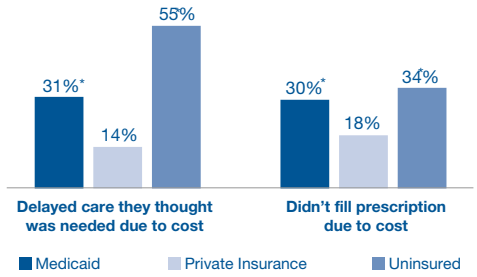


Note: *Includes women 18 to 64. **Includes women 50-74. ***Includes women 21-65.
Source: Agency for Healthcare Research and Quality, Medical Expenditures Panel Survey, 2010 and Centers for Disease Control and Prevention, *MMWR, Cancer Screening - US, 2010*, 2012.

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*

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.[24]

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. Due to the most recent recession as Medicaid rolls 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.[25] States are not permitted to charge cost-sharing to pregnant women, children, or for family planning services.

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 66% of Medicare fees on average, and this ratio varies across states, and in many states is even lower.[26] 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. 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%).[27] 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 brings 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. 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.

In June 2012, the Supreme Court ruled on various aspects related to the constitutionally of both the insurance mandate and the Medicaid expansion. While the ACA was upheld, a majority of the Court found that the ACA Medicaid expansion was unconstitutionally coercive to the States. While states could expand Medicaid if they choose to, HHS authority to enforce the expansion requirement was removed, effectively allowing states to decide if they wanted to expand their program. All of the other Medicaid-related provisions and reforms, however, remained intact and enforceable.

In states that expand their programs, there will no longer be categorical requirements for Medicaid eligibility, women who have no children or are not pregnant will be eligible for coverage if their income is below 138% of the federal poverty level. A recent analysis estimates that as many as 7 million currently uninsured women could qualify for Medicaid under the ACA.[28] Despite the opportunity to expand coverage, it is likely that millions of low income women may not qualify for assistance under the ACA expansion: some states will not choose to broaden Medicaid eligibility; federal law has a five year ban on Medicaid for new immigrants; and undocumented immigrants are not eligible for assistance under the new law.

The ACA also 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. This measure could improve provider participation rates. There are still concerns about having a primary care 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. 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. State Medicaid programs will receive a 1% increase in the federal matching rate if they cover, without cost sharing, all the 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.[29]

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. States will have a tremendous opportunity to expand coverage to some of the poorest women, who have historically not had access to coverage. However, states that do not expand their Medicaid program will leave potentially hundreds of thousands of the poorest uninsured women without a pathway to coverage. 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.

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

ENDNOTES

[1] Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2009 MSIS.

[2] Kaiser Commission on Medicaid and the Uninsured (KCMU,) Holding Steady, *Looking Ahead: Annual Findings of A 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010-2011*, January 2011.

[3] State Health Facts Online, (SHFO): www.statehealthfacts.org/comparereport.jsp?rep=130&cat=4

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[6] KCMU analysis of 2009 MSIS.

[7] KFF analysis of Urban Institute estimates from 2012 ASEC supplement, U.S. Census Bureau.

[8] Sonfield A, and Gold RB, Public funding for family planning, sterilization and abortion services, FY 1980–2010, Guttmacher Institute, 2012.

[9] KFF/Guttmacher, *Medicaid's Role in Family Planning*, 2007.

[10] KFF, *State Medicaid Coverage of Family Planning Services*, 2009.

[11] Letter from Donald M. Berwick, Admin., DHHS Servs., to Patricia Casanova, Director, Office of Medicaid Policy and Planning (June 1, 2011).

[12] Sonfield A and Gold RB, *Medicaid Family Planning Expansions: Lessons Learned and Implications for the Future*, New York: Guttmacher Institute, 2011.

[13] Guttmacher Institute, *Medicaid Family Planning Expansions*, November 2012.

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[17] KFF, State Medicaid Coverage of Perinatal Services, 2009.

[18] KCMU, *Holding Steady, Looking Ahead: Annual Findings of A 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010-2011*, January 2011.

[19] GAO, *Screening Affects Women's Eligibility for Coverage of Breast and Cervical Cancer Treatment in Some States*, June 2009.

[20] Kaiser Family Foundation, KaiserEDU Tutorial, Dual Eligibles 2012.

[21] The Scan Foundation, *The Financing of Long Term Care*, 2010.

[22] KCMU, *Medicaid and Long-Term Care Services and Supports*, March 2011.

[23] Agency for Healthcare Research and Quality, Medical Expenditures Panel Survey, 2010. And Centers for Disease Control and Prevention, *MMWR, Cancer Screening- US, 2010*, 2012.

[24] Kaiser Family Foundation, *Medicaid Benefits: Online Database*.

[25] KCMU, *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends*, October 2011.

[26] KCMU, *How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees*, 2012.

[27] KFF, *2008 Kaiser Women's Health Survey*.

[28] Kenney G, et al. *Opting in to the Medicaid Expansion under the ACA: Who are the Uninsured Adults Who Could Gain Health Insurance Coverage?* Urban Institute, 2012.

[29] Sebelius, K, Progress Continues Setting up Health Insurance Marketplaces, 2012.

Table 1:
State Level Estimates of Women Over 18 Enrolled in Medicaid, by Age, 2009

	Total Number of Women Enrolled in Medicaid, by State	Ages 18-44, Percent of Total Women on Medicaid	Ages 45-64, Percent of Total Women on Medicaid	Ages 65+, Percent of Total Women on Medicaid
Alabama	33,670	66%	18%	16%
Alaska	356,567	57%	18%	25%
Arizona	241,833	63%	17%	20%
Arkansas	567,360	67%	21%	12%
California	4,909,664	74%	13%	13%
Colorado	183,735	66%	15%	19%
Connecticut	215,464	59%	18%	23%
Delaware	63,241	59%	25%	16%
District of Columbia	77,581	66%	21%	13%
Florida	1,142,879	57%	17%	26%
Georgia	552,383	59%	18%	22%
Hawaii	83,868	59%	23%	19%
Idaho	190,727	66%	18%	16%
Illinois	58,579	62%	18%	20%
Indiana	910,046	67%	17%	16%
Iowa	365,550	64%	19%	17%
Kansas	108,391	56%	20%	24%
Kentucky	301,596	55%	23%	22%
Louisiana	392,544	63%	17%	20%
Maine	645,243	55%	27%	18%
Maryland	306,629	63%	20%	17%
Massachusetts	142,679	52%	20%	28%
Michigan	667,586	67%	18%	14%
Minnesota	324,785	64%	16%	20%
Mississippi	350,870	60%	21%	19%
Missouri	265,952	57%	19%	24%
Montana	35,109	59%	20%	21%
Nebraska	623,338	60%	18%	21%
Nevada	25,962	60%	16%	24%
New Hampshire	66,204	55%	20%	26%
New Jersey	48,702	57%	20%	23%
New Mexico	318,992	49%	18%	33%
New York	158,443	70%	15%	15%
North Carolina	84,625	62%	17%	20%
North Dakota	2,033,048	55%	25%	20%
Ohio	741,883	64%	19%	17%
Oklahoma	250,941	62%	19%	19%
Oregon	189,033	59%	21%	20%
Pennsylvania	805,249	59%	20%	21%
Rhode Island	73,501	51%	21%	28%
South Carolina	320,084	64%	17%	19%
South Dakota	36,024	60%	16%	24%
Tennessee	528,705	60%	20%	20%
Texas	1,180,854	60%	15%	25%
Utah	93,194	71%	18%	11%
Vermont	306,696	57%	19%	25%
Virginia	68,418	54%	26%	20%
Washington	365,119	67%	17%	16%
West Virginia	425,477	62%	13%	25%
Wisconsin	140,452	53%	26%	20%
Wyoming	22,129	66%	16%	18%

Note: The federal poverty level (FPL) for a family of three in 2010 was $18,310

Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute estimates of MSIS, FY 2009.

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