NATIONAL WOMEN'S LAW CENTER

EXPANDING THE POSSIBILITIES

states must close the gap:

low-income women need health insurance

ABOUT THE CENTER

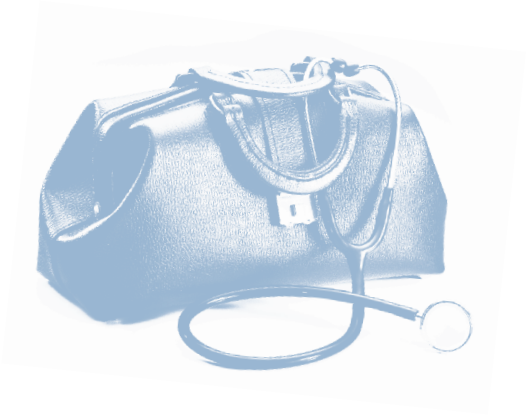
The National Women's Law Center is a non-profit organization whose mission is to expand the possibilities for women and girls by working to remove barriers based on gender, open opportunities, and help women and their families lead economically secure, healthy, and fulfilled lives—especially low-income women and their families.

ACKNOWLEDGMENTS

The report was a collaborative endeavor that relied upon the work of many individuals. The primary author of the report was Stephanie Glover, with assistance from Karen Davenport, Marcia Greenberger, and Judy Waxman. We also appreciate the work of Danielle Garrett and Kimberly Miller-Tolbert who contributed to the earlier version of this report. Beth Stover designed the report with layout assistance provided by Nancy Magill.

To download a copy of the original report, Mind the Gap: Women in Dire Need of Health Insurance, please go to www.nwlc.org/mindthegap.

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES



states must close the gap:

low-income women need health insurance

table of contents

states must close the gap: low-income women need health insurance

October 2014

Access and preventive care disparities between low-income women with and without insurance demonstrate the importance of Medicaid in states yet to expand coverage

Over three million low-income women in the United States fall into a coverage gap and are uninsured, regardless of the fact that they are eligible for coverage under the Affordable Care Act (ACA). This gap is the direct result of 22 states' failure to use federal money already set aside to expand health care coverage through Medicaid.

The consequences are predictable: low-income women without health insurance report being unable to afford necessary health care more than two and a half times as often as their insured counterparts. In Oklahoma, for example, the number of low-income women reporting that they had received their recommended mammograms more than doubled when the women also reported having insurance. And in Texas, insured low-income women report having a regular health care provider twice as often as low-income women without health coverage.

Under the ACA, all states—including the 22 in question—can expand Medicaid coverage to individuals with incomes below 138 percent of the federal poverty level (approximately $16,000 for an individual), but who do not qualify for traditional Medicaid based on disability, family composition or age. In addition, women with income above the poverty level are eligible for subsidies for private health insurance available through their state Marketplace. When states turn down the federal money, a coverage gap exists for women with incomes between traditional Medicaid eligibility and those above poverty.

This updated report again demonstrates the risk the coverage gap poses to low-income women's health by examining the dramatic differences in health care access and preventive services utilization between low-income women who will be stuck in this coverage gap—unless their state changes course—versus those who have access to coverage. This analysis finds that women in the coverage gap also experience a health care gap.

medicaid expansion: a keystone of the affordable care act, before and after the supreme court

As enacted, the Affordable Care Act (ACA) extended health coverage to 14 million uninsured American women, with roughly half of this population gaining health coverage through expanded Medicaid eligibility and the other half through tax credits to purchase private insurance. Before the ACA, whether a woman qualified for Medicaid coverage depended on not only her income, but also her age, whether she was pregnant, whether she had children, and whether she had a disability. The law expanded Medicaid eligibility to all qualified individuals under age 65 who have incomes below 138 percent of the federal poverty line (FPL), or just over $32,000 for a family of four, with the federal government covering 100 percent of Medicaid spending on health services for the newly-covered population in the first three years of implementation, and at least 90 percent in later years.[1] In the vast majority of states, this marked the first time that low-income, childless women would have access to Medicaid coverage.

In 2012, however, the Supreme Court held that states are not required to expand Medicaid coverage as a condition of receiving federal matching funding for the traditional Medicaid program. Under the Court's ruling, states can choose whether or not to accept the federal money to cover more individuals through Medicaid. The Centers for Medicare and Medicaid Services (CMS) has made clear that states may choose to expand coverage at any time and receive the enhanced matching rate that applies to the year the state's expansion begins. States that choose to use the new federal funding and expand coverage may also drop it at any time if they so choose.[2]

Twenty-eight states (including the District of Columbia) have chosen to expand their Medicaid program at this time.[3] But in the 22 states that have not yet expanded Medicaid coverage, over three million women will have no affordable coverage options and will fall into the resulting coverage gap.[4] Table 1 shows the number of women who are left without health insurance in the 22 states that have not yet expanded coverage.

Since this report was first issued in early 2014, two states have accepted federal funds to expand Medicaid coverage. Pennsylvania and New Hampshire expanded coverage through Medicaid to a combined 196,000 women who previously fell into the coverage gap.[5] Women in these states will now have access to comprehensive health care they can afford.

TABLE 1: WOMEN LEFT IN THE COVERAGE GAP, BY STATE

States	Number of Women in the Coverage Gap	Women in the Coverage Gap, as Percentage of Uninsured Womaen
Texas	794,000	36.4%
Florida	509,000	33.1%
Georgia	283,000	43.9%
North Carolina	197,000	29.8%
Louisiana	157,000	63.3%
Indiana	140,000	46.8%
Missouri	134,000	53.0%
Alabama	129,000	41.0%
Virginia	127,000	33.8%
Tennessee	112,000	30.9%
South Carolina	111,000	38.5%
Mississippi	101,000	59.8%
Oklahoma	89,000	38.2%
Kansas	51,000	52.0%
Utah	45,000	39.5%
Idaho	38,000	44.2%
Nebraska	26,000	38.2%
Montana	25,000	39.1%
South Dakota	16,000	72.7%
Maine	14,000	29.8%
Wyoming	11,000	28.9%
Alaska	10,000	28.6%
Total	**3,119,000**	**52.3%**

Note: In most states, the estimated number of women in the coverage gap is higher than we reported in our January 2014 report. The updated information reflects the most current information available on who would be ineligible for coverage due to nonexpansion. Overall, the total number of women in the coverage gap is roughly equal to the total estimate in the first version of our report, despite two states having expanded coverage in the last ten months.

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

Sources: Kaiser Family Foundation, "Status of State Action on Medicaid Expansion Decision, Updated October 2014, available at http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/; Stan Dorn et. al., the Urban Institute, "In States That Don't Expand Medicaid, Who Gets New Coverage Assistance Under the ACA and Who Doesn't? Chart Pack," available at http://www.urban.org/publications/413248.html; NWLC analysis of U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2014.

states must close the gap: women in the coverage gap also experience a health care gap

While access to affordable health coverage is important for everyone, it is a particularly salient issue for women. Women more often manage multiple chronic conditions and pay more in out-of-pocket costs, which makes them particularly vulnerable to health care costs.[6] As a result, their health care needs go unmet, with women routinely foregoing needed services and care. One in four women reported going without needed health care because they could not afford it and nearly two-thirds of all uninsured women report heath care cost as major barrier to care.[7]

This report examines the health care access and utilization of uninsured women who would generally be eligible for Medicaid, if their state expanded the program, to illustrate how these women could benefit from expanded coverage. This analysis finds that these women fare significantly worse in our health care system than insured women with similar family incomes. More specifically, we examined responses to questions from the Centers for Disease Control's Behavioral Risk Factor Surveillance System survey assessing access and utilization among two groups of women—uninsured women in households with an annual income of less than $35,000 and women within the same income range who currently have some form of health coverage. This income level approximates eligibility for the coverage expansion for a woman living in a family of between four and five people, and ensures that the analysis captures women who fall into the coverage gap (who will have somewhat lower incomes). Across nearly all of these measures, which include general access measures indicative of integration into the health care system and utilization measures for several preventive services that states must cover for individuals eligible for expanded Medicaid coverage, women who would be eligible for Medicaid coverage fare worse than insured women with the same income. This is true on a national level as well as on a state level in the 22 states that have not expanded Medicaid.

Uninsured women fare significantly worse in our health care system than women with insurance.

UNINSURED WOMEN HAVE LESS ACCESS TO CARE

Without health coverage, low-income women have less access to basic care. As Table 2 shows, cost creates a significant barrier to care for low-income women. Approximately 59 percent of low-income women without health insurance report that cost prevented them from seeing a doctor at least once in the last 12 months, which is nearly 170 percent more than the 22 percent of low-income women with health coverage who report cost as a barrier to care. In addition, approximately 54 percent of low-income, uninsured women report having a personal doctor or health care provider compared to 85 percent of low-income women with health insurance—a difference of almost 60 percent. Similarly, 62 percent of low-income uninsured women report having had a regular checkup in the last two years, which is 40 percent less than the 87 percent of low-income, insured women who had a regular visit during this time frame.

TABLE 2: UNINSURED, LOW-INCOME WOMEN HAVE WORSE ACCESS TO BASIC HEALTH CARE

Question	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	59.0%	22.1%
Have a personal doctor or health care provider	54.2%	85.5%
Had a "regular checkup" in the last two years	62.2%	87.1%

* For this question alone, a higher percentage means that fewer women are accessing care.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

UNINSURED, LOW-INCOME WOMEN AVOID CARE BECAUSE OF COST

These national statistics reflect an average of survey responses across all 50 states, and in many of the states choosing not to expand Medicaid the disparities are even worse. For example, in Maine and South Dakota, low-income, uninsured women report going without care because of cost three times as often as low-income women with health insurance. Table 3 shows that a number of additional states post differences well above the national average. When women go without care because of cost, they may postpone diagnosis of a serious health problem, go without needed treatment, or incur financial losses related to missed work due to illness.

TABLE 3: LOW-INCOME WOMEN WHO NEEDED TO SEE A DOCTOR BUT COULD NOT BECAUSE OF COST AT SOME POINT IN THE LAST 12 MONTHS

State	Low-Income Women without Insurance	Low-Income Women with Insurance
Alabama	67.7%	23.5%
Alaska	51.8%	19.6%
Florida	61.3%	28.2%
Georgia	66.3%	26.2%
Idaho	57.0%	24.6%
Indiana	63.2%	24.4%
Kansas	58.4%	21.6%
Louisiana	59.0%	28.1%
Maine	43.1%	13.4%
Mississippi	64.3%	28.6%
Missouri	58.8%	24.3%
Montana	47.3%	20.0%
Nebraska	56.6%	18.7%
North Carolina	61.9%	27.8%
Oklahoma	64.4%	24.6%
South Carolina	64.6%	26.3%
South Dakota	51.3%	22.4%
Tennessee	57.1%	25.1%
Texas	59.8%	30.2%
Utah	57.2%	26.0%
Virginia	62.0%	23.1%
Wyoming	56.5%	21.5%

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm.

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

Disparities in other access measures also frequently exceed national averages. Women who have a personal physician or other usual source of care can turn to their provider for regular preventive services, seek help with new health problems, and obtain referrals for needed specialty services. Women without a usual source of care have greater difficulty connecting to the health care system—and experience poorer health outcomes, increased health disparities, and higher health care costs. Women without health insurance, in comparison to those with coverage, were less likely to report having a usual source of care. For example, insured, low-income women in Texas report having a regular health care provider twice as often as low-income women without health coverage, in comparison to an average health access gap of 40 percent (Table 4). Another three states—Florida, Oklahoma, and Texas—post gaps that are double this national rate.

TABLE 4: LOW-INCOME WOMEN WITH A PERSONAL DOCTOR OR HEALTH CARE PROVIDER

State	Low-Income Women without Insurance	Low-Income Women with Insurance
Alabama	58.1%	88.0%
Alaska	51.5%	72.8%
Florida	47.7%	86.0%
Georgia	50.6%	83.0%
Idaho	58.2%	82.6%
Indiana	56.5%	89.4%
Kansas	53.3%	85.7%
Louisiana	53.9%	86.9%
Maine	69.3%	92.5%
Mississippi	61.2%	90.4%
Missouri	53.3%	88.2%
Montana	59.6%	77.7%
Nebraska	66.0%	85.6%
North Carolina	54.7%	85.9%
Oklahoma	46.7%	81.6%
South Carolina	60.1%	85.5%
South Dakota	63.1%	73.4%
Tennessee	51.6%	85.3%
Texas	39.2%	81.9%
Utah	58.7%	81.0%
Virginia	60.1%	84.0%
Wyoming	64.4%	80.1%

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm.

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

Similarly, women who have regular health exams are more likely to have their provider identify health problems before they start, or early enough that they have a greater opportunity for treatment and cure. However, insured low-income Idaho women report having had a regular check-up in the last two years 1.5 times as often as low-income women without health coverage—even though the national disparity averages 40 percent. Other states with notable disparities include Florida, Montana, and Oklahoma (see Table 5).

These differences in health care access are great, but states have an immediate tool at hand to address this gap in access to regular health care services for low-income uninsured women. By expanding coverage through Medicaid, states can integrate millions of low-income women into our health care system.

TABLE 5: LOW-INCOME WOMEN WHO HAVE HAD A REGULAR CHECKUP IN THE PAST TWO YEARS

State	Low-Income Women without Insurance	Low-Income Women with Insurance
Alabama	69.7%	90.2%
Alaska	46.0%	78.7%
Florida	60.8%	87.2%
Georgia	67.3%	90.8%
Idaho	50.0%	78.8%
Indiana	56.9%	86.5%
Kansas	62.4%	87.3%
Louisiana	81.0%	93.7%
Maine	69.0%	89.4%
Mississippi	65.2%	89.6%
Missouri	57.8%	84.8%
Montana	52.7%	80.7%
Nebraska	57.7%	80.6%
North Carolina	72.6%	90.5%
Oklahoma	52.2%	80.6%
South Carolina	64.5%	87.7%
South Dakota	62.1%	83.8%
Tennessee	70.3%	93.7%
Texas	66.2%	86.5%
Utah	56.7%	80.5%
Virginia	70.0%	88.4%
Wyoming	53.9%	80.1%

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm.

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

UNINSURED WOMEN HAVE LIMITED USE OF PREVENTIVE SERVICES

Preventive services allow individuals to catch problems earlier and begin treatment, when necessary, in a timely manner, avoid more serious diseases down the line, and ultimately live healthier, longer lives. But without health insurance coverage, low-income, uninsured women have trouble accessing these important preventive services, and use preventive care less than low-income insured women. Table 6 highlights the differences in service utilization for several recommended preventive services that health insurance must cover under the ACA.

Uninsured low-income women receive preventive services at rates below that of insured low-income women. The biggest difference was for flu vaccines, with uninsured women receiving the vaccine at a rate more than 70 percent lower than insured women. Low-income uninsured women also have lower rates of important cancer screenings. For example, uninsured low-income women receive colonoscopies, which can not only detect, but in some cases prevent colon cancer, at a rate nearly 70 percent lower than insured low-income women. The rate of cervical cancer screenings, which have been shown to significantly reduce the incidence of cervical cancer and mortality over time, was nearly 25 percent lower for uninsured low-income women than for insured low-income women, and the rate of mammograms was nearly 60 percent lower.[8] One discrepancy was HIV testing, which had a statistically insignificant difference between insured and uninsured low-income women. On the state level, many of the differences are also insignificant and in some states, uninsured women actually have slightly higher rates of testing. These results are not surprising given the extensive efforts to expand access to HIV testing for populations that are at high risk for this disease, and these high-risk groups are also likely to be low-income and uninsured.

In several of the states that have not expanded coverage through the Medicaid program, the gap between low-income uninsured women and low-income women with health insurance is even larger than the national gap between these two groups for these important services. In Oklahoma, for example, insured low-income women receive their recommended mammograms approximately 2.3 times as often as low-income women without insurance, while insured low-income women in Florida and Texas report receiving recommended colon cancer screenings at twice the rate of uninsured women. The largest differences were in Florida, Georgia, Maine, and Missouri, where insured low-income women receive a seasonal flu vaccine at double the rate of women without insurance.

TABLE 6: LOW-INCOME WOMEN WHO HAVE HAD A PREVENTIVE CARE CHECKUP IN THE PAST TWO YEARS

Question	Low-Income Women without Insurance	Low-Income Women with Insurance
Had a mammogram in the past two years (aged 40+)*	45.5%	72.2%
Had a sigmoidoscopy or colonoscopy (aged 50+)*	37.1%	62.4%
Had a Pap test in the past three years (18+)*	65.3%	80.8%
Ever tested for HIV**	47.6%	47.8%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	23.0%	39.4%

* These questions are based on BRFSS data from 2012.
** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

According to research, expanding coverage through Medicaid should improve women's access to preventive services like flu shots and screenings for conditions like HIV and cancer. For example, according to researchers from the Massachusetts Institute of Technology and Harvard University, individuals newly covered by the Oregon Medicaid program increased their utilization of hospital care, outpatient services, and prescription drugs, and their compliance with recommended preventive care.[9] By expanding coverage through Medicaid, states can reduce the gap in women's use of preventive services, ultimately improving their health.

TABLE 7: LOW-INCOME WOMEN OVER 40 WHO HAVE HAD A MAMMOGRAM IN THE PAST TWO YEARS

State	Low-Income Women without Insurance	Low-Income Women with Insurance
Alabama	47.4%	75.4%
Alaska	37.7%	69.9%
Florida	37.2%	72.7%
Georgia	45.6%	79.5%
Idaho	28.8%	57.5%
Indiana	37.7%	69.1%
Kansas	42.2%	71.1%
Louisiana	62.1%	76.7%
Maine	50.3%	77.7%
Mississippi	41.4%	73.1%
Missouri	43.4%	66.2%
Montana	41.5%	65.2%
Nebraska	40.5%	61.6%
North Carolina	49.1%	77.3%
Oklahoma	28.1%	64.7%
South Carolina	51.2%	75.2%
South Dakota	50.0%	73.8%
Tennessee	41.9%	72.8%
Texas	43.3%	71.4%
Utah	34.5%	65.7%
Virginia	52.1%	76.3%
Wyoming	29.1%	59.2%

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm.

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

TABLE 8: LOW-INCOME WOMEN OVER 50 WHO HAVE HAD A COLON CANCER SCREENING

State	Low-Income Women without Insurance	Low-Income Women with Insurance
Alabama	43.3%	66.4%
Alaska	33.3%	65.5%
Florida	33.5%	72.0%
Georgia	40.8%	64.8%
Idaho	31.0%	56.9%
Indiana	26.0%	62.2%
Kansas	43.9%	63.1%
Louisiana	37.1%	58.5%
Maine	47.4%	74.4%
Mississippi	30.0%	59.5%
Missouri	41.9%	61.8%
Montana	32.5%	50.9%
Nebraska	31.7%	54.1%
North Carolina	40.3%	67.1%
Oklahoma	28.6%	54.5%
South Carolina	38.5%	67.6%
South Dakota	29.3%	56.3%
Tennessee	36.9%	67.7%
Texas	30.7%	62.5%
Utah	39.8%	67.1%
Virginia	35.8%	70.7%
Wyoming	32.7%	58.3%

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm.

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

TABLE 9: LOW-INCOME WOMEN OVER 18 WHO HAVE HAD A PAP TEST IN THE LAST 3 YEARS

State	Low-Income Women without Insurance	Low-Income Women with Insurance
Alabama	69.5%	83.0%
Alaska	64.4%	79.3%
Florida	61.6%	79.3%
Georgia	65.6%	82.5%
Idaho	56.4%	74.6%
Indiana	59.9%	78.7%
Kansas	68.6%	81.8%
Louisiana	70.9%	83.7%
Maine	68.4%	86.0%
Mississippi	67.8%	82.8%
Missouri	60.3%	77.4%
Montana	63.3%	76.9%
Nebraska	65.2%	76.8%
North Carolina	70.1%	84.7%
Oklahoma	63.4%	76.9%
South Carolina	67.4%	83.4%
South Dakota	68.9%	82.3%
Tennessee	65.6%	82.4%
Texas	67.7%	80.8%
Utah	63.5%	71.8%
Virginia	69.4%	81.5%
Wyoming	58.9%	74.2%

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm.

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

TABLE 10: LOW-INCOME WOMEN WHO HAVE EVER BEEN TESTED FOR HIV

State	Low-Income Women without Insurance	Low-Income Women with Insurance
Alabama	62.7%	47.9%
Alaska*	54.4%	55.5%
Florida*	55.1%	57.0%
Georgia	58.2%	50.5%
Idaho*	42.7%	41.7%
Indiana	47.3%	41.8%
Kansas	47.4%	41.3%
Louisiana*	59.9%	55.4%
Maine*	37.4%	42.8%
Mississippi*	53.4%	47.8%
Missouri*	52.7%	47.0%
Montana*	37.6%	40.8%
Nebraska	40.8%	32.9%
North Carolina	62.4%	55.1%
Oklahoma*	40.4%	43.8%
South Carolina*	51.0%	47.4%
South Dakota	38.5%	39.5%
Tennessee*	44.0%	53.7%
Texas*	44.9%	47.0%
Utah	42.1%	35.8%
Virginia	57.2%	46.6%
Wyoming*	37.5%	39.3%

*The difference between the two groups is not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm.

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

TABLE 11: LOW-INCOME WOMEN WHO HAVE HAD EITHER A SEASONAL FLU SHOT OR A SEASONAL FLU VACCINE THAT WAS SPRAYED THROUGH THE NOSE IN THE PAST 12 MONTHS

State	Low-Income Women without Insurance	Low-Income Women with Insurance
Alabama	22.4%	40.8%
Alaska	21.6%	36.2%
Florida	14.6%	29.3%
Georgia	16.3%	35.1%
Idaho	17.8%	33.2%
Indiana	23.3%	36.9%
Kansas	21.7%	42.3%
Louisiana	26.7%	48.2%
Maine	22.9%	46.9%
Mississippi	18.0%	35.6%
Missouri	22.4%	46.4%
Montana	23.5%	42.3%
Nebraska	24.1%	42.6%
North Carolina	29.1%	44.0%
Oklahoma	26.8%	45.9%
South Carolina	20.9%	37.0%
South Dakota	32.6%	53.3%
Tennessee	33.1%	49.6%
Texas	22.1%	39.4%
Utah	20.6%	38.5%
Virginia	24.6%	43.0%
Wyoming	24.7%	39.2%

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm.

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

states must close the gap: other gaps in care for low-income, uninsured women

In the absence of new coverage through Medicaid, low-income, uninsured women must rely on a patchwork of fragmented programs to receive only some of the health services they need. The federal and state programs that provide health coverage or direct services are often limited, and many women cannot access them at all. For example, pregnant women in states that have not expanded Medicaid coverage under the ACA are often able to obtain Medicaid coverage for the limited duration of their pregnancy, but eligibility and covered services can vary from state to state; the Centers for Disease Control and Prevention funds breast and cervical cancer screenings for some—although not all—qualified low-income women in each state; and a number of federal, state, and local programs offer access to HIV testing, but cannot help all women who need this service.

The picture is similarly limited for reproductive health. For example, the Title X program, which funds no-cost or low-cost family planning services at family planning clinics, provides crucial services but is generally underfunded and cannot meet demand. And states do not always use all of the available programmatic and budget options at their disposal to improve women's access to reproductive health services. For example, states can provide Medicaid coverage of family planning services for low-income individuals who do not qualify for traditional Medicaid; however, nine of the states that have failed to expand Medicaid coverage have also failed to expand coverage for family planning services.[10]

Expanding coverage through Medicaid will address many of these shortcomings. Women who enroll in Medicaid coverage will have comprehensive health insurance—coverage that includes important preventive screenings, maternity care, family planning services, and other services that today's patchwork of programs cannot deliver to all low-income, uninsured women.

In the absence of Medicaid coverage, low-income uninsured women rely on a patchwork of programs for health services.

states must close the gap: conclusion

Overall, the gap between low-income, uninsured women and low-income women with health insurance on critical access and prevention measures demonstrates that going without health insurance is bad for women's health. This analysis shows that low-income uninsured women—who would be eligible for health insurance if their state accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, states accept this federal money and expand coverage through Medicaid, thus eliminating the coverage gap, they would ensure that all low-income women can access the care they need to lead healthier lives.

states must close the gap: methodology

DATA

To update this report, we analyze data from the 2013 Behavior Risk Factor Surveillance Survey (BRFSS). For the questions about cancer screenings, we continued to use data from the 2012 survey because those questions were not included in the core questions of the most recent survey, thus we couldn't provide updated state level data for mammograms, colon cancer screenings, and Pap tests. The BRFSS data is derived from surveys conducted by state health departments in conjunction with the Centers for Disease Control and Prevention (CDC). The BRFSS surveys non-institutionalized adults in every state about their health risk behaviors, preventive health choices, access to health care services, and basic demographic information. We chose this source because of its large sample size, variety of questions, and very current data. It was also the most robust data source available that we could analyze by state, gender, income, and insurance status.[11]

DEFINING LOW-INCOME WOMEN

Our analysis compares insured and uninsured women between the ages of 18 and 64. In order to provide a useful analysis, we wanted to make sure our uninsured category reasonably approximated the Medicaid eligible population while still maintaining sample sizes large enough for a valid analysis. To this end, we decided to define low-income women as women with incomes at or below $35,000. Thirty-five thousand dollars is the income break available in BRFSS that comes closest to 138 percent of the federal poverty line for a family containing between 4 and 5 people (an average sized American family). Although we know this income level is over inclusive and will include women with smaller families who will not be eligible for Medicaid, we can feel reasonably sure we are capturing the majority of those newly eligible.

While women at or below 138 percent of the federal poverty level would qualify for Medicaid coverage, the coverage "gap" refers to people at or below 100 percent FPL, whose incomes fall below the level where tax credits to buy private insurance become available. So while our data is a rough approximation of Medicaid eligibility, rather than an approximation of the coverage gap, this should not impact the general conclusions derived from the data, because women in the coverage gap are even lower income and thus would be expected to have as much difficulty, if not more difficulty, accessing care than individuals with family incomes up to 138 percent FPL.

ALABAMA

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Alabama has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Alabama accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Alabama accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Alabama. Notable findings include:

- For uninsured women in Alabama, cost is a major barrier to care—over 68 percent of uninsured women face cost as an obstacle when seeking care, compared to only 24 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 47 percent of uninsured women in Alabama receive a recommended mammogram compared to 75 percent of insured women.
- Uninsured women in Alabama go without needed health care because of cost more often than women nationally and also fall short of the national average for rates of flu vaccines.

ALABAMA

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	67.7%	23.5%
Have a personal doctor or health care provider	58.1%	88.0%
Had a "regular checkup" in the last two years	69.7%	90.2%
Had a mammogram in the past two years (aged 40+)**	47.4%	75.4%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	43.3%	66.4%
Had a Pap test in the past three years (18+)**	69.5%	83.0%
Ever tested for HIV	62.7%	47.9%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	22.4%	40.8%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

ALASKA

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Alaska has not yet expanded coverage. This analysis shows that low-income uninsured women— many of whom would be eligible for health insurance if Alaska accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Alaska accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Alaska. Notable findings include:

- For uninsured women in Alaska, cost is a major barrier to care—over 52 percent of uninsured women face cost as an obstacle when seeking care, compared to only 20 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 38 percent of uninsured women in Alaska receive a recommended mammogram compared to 70 percent of insured women.
- Uninsured women in Alaska also fall short of the national average for all of the indicators below except HIV testing.

ALASKA

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	51.8%	19.6%
Have a personal doctor or health care provider	51.5%	72.8%
Had a "regular checkup" in the last two years	46.0%	78.7%
Had a mammogram in the past two years (aged 40+)**	37.7%	69.9%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	33.3%	65.5%
Had a Pap test in the past three years (18+)**	64.4%	79.3%
Ever tested for HIV	54.4%	55.5%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	21.6%	36.2%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

FLORIDA

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Florida has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Florida accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Florida accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Florida. Notable findings include:

- For uninsured women in Florida, cost is a major barrier to care—over 61 percent of uninsured women face cost as an obstacle when seeking care, compared to only 28 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 37 percent of uninsured women in Florida received a recommende mammogram compared to 73 percent of insured women.
- Uninsured women in Florida also fall short of the national average for their rates of mammograms, colon cancer screenings, cervical cancer screenings, and flu vaccines.

FLORIDA

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	61.3%	28.2%
Have a personal doctor or health care provider	47.7%	86.0%
Had a "regular checkup" in the last two years	60.8%	87.2%
Had a mammogram in the past two years (aged 40+)**	37.2%	72.7%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	33.5%	72.0%
Had a Pap test in the past three years (18+)**	61.6%	79.3%
Ever tested for HIV***	55.1%	57.0%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	14.6%	29.3%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.
*** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

GEORGIA

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Georgia has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Georgia accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Georgia accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Georgia. Notable findings include:

- For uninsured women in Georgia, cost is a major barrier to care—over 66 percent of uninsured women face cost as an obstacle when seeking care, compared to only 26 percent of insured women.
- Uninsured women utilize preventive services at lower rates; for example only 46 percent of uninsured women in Georgia receive a recommended mammogram compared to 80 percent of insured women.
- Uninsured women in Georgia also fall short of the national average for their rates of flu vaccines.

GEORGIA

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	66.3%	26.2%
Have a personal doctor or health care provider	50.6%	83.0%
Had a "regular checkup" in the last two years	67.3%	90.8%
Had a mammogram in the past two years (aged 40+)**	45.6%	79.5%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	40.8%	64.8%
Had a Pap test in the past three years (18+)**	65.6%	82.5%
Ever tested for HIV	58.2%	50.5%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	16.3%	35.1%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

IDAHO

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Idaho has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Idaho accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Idaho accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Idaho. Notable findings include:

- For uninsured women in Idaho, cost is a major barrier to care—57 percent of uninsured women face cost as an obstacle when seeking care, compared to only 25 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 29 percent of uninsured women in Idaho receive a recommended mammogram compared to 58 percent of insured women.
- Uninsured women in Idaho also fall short of the national average for their rates of mammograms, colon cancer screenings, cervical cancer screenings, and flu vaccines.

IDAHO

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	57.0%	24.6%
Have a personal doctor or health care provider	58.2%	82.6%
Had a "regular checkup" in the last two years	50.0%	78.8%
Had a mammogram in the past two years (aged 40+)**	28.8%	57.5%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	31.0%	56.9%
Had a Pap test in the past three years (18+)**	56.4%	74.6%
Ever tested for HIV***	42.7%	41.7%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	17.8%	33.2%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

*** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

INDIANA

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Indiana has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Indiana accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Indiana accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Indiana. Notable findings include:

- For uninsured women in Indiana, cost is a major barrier to care—over 63 percent of uninsured women face cost as an obstacle when seeking care, compared to only 24 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 38 percent of uninsured women in Indiana receive a recommended mammogram compared to 69 percent of insured women.
- Uninsured women in Indiana also fall short of the national average for their rates of mammograms, colon cancer screenings, and cervical cancer screenings.

INDIANA

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	63.2%	24.4%
Have a personal doctor or health care provider	56.5%	89.4%
Had a "regular checkup" in the last two years	56.9%	86.5%
Had a mammogram in the past two years (aged 40+)**	37.7%	69.1%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	26.0%	62.2%
Had a Pap test in the past three years (18+)**	59.9%	78.7%
Ever tested for HIV	47.3%	41.8%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	23.3%	36.9%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

KANSAS

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Kansas has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Kansas accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Kansas accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Kansas. Notable findings include:

- For uninsured women in Kansas, cost is a major barrier to care—over 58 percent of uninsured women face cost as an obstacle when seeking care, compared to only 22 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 42 percent of uninsured women in Kansas receive a recommended mammogram compared to 71 percent of insured women.
- Additionally, only 69 percent of uninsured women receive a recommended Pap test compared to 82 percent of insured women in Kansas.

KANSAS

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	58.4%	21.6%
Have a personal doctor or health care provider	53.3%	85.7%
Had a "regular checkup" in the last two years	62.4%	87.3%
Had a mammogram in the past two years (aged 40+)**	42.2%	71.1%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	43.9%	63.1%
Had a Pap test in the past three years (18+)**	68.6%	81.8%
Ever tested for HIV	47.4%	41.3%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	21.7%	42.3%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

LOUISIANA

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Louisiana has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Louisiana accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Louisiana accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Louisiana. Notable findings include:

- For uninsured women in Louisiana, cost is a major barrier to care—over 59 percent of uninsured women face cost as an obstacle when seeking care, compared to only 28 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 62 percent of uninsured women in Louisiana receive a recommended mammogram compared to 77 percent of insured women.
- Additionally, only 71 percent of uninsured women receive a recommended Pap test compared to 84 percent of insured women in Louisiana.

LOUISIANA

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	59.0%	28.1%
Have a personal doctor or health care provider	53.9%	86.9%
Had a "regular checkup" in the last two years	81.0%	93.7%
Had a mammogram in the past two years (aged 40+)**	62.1%	76.7%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	37.1%	58.5%
Had a Pap test in the past three years (18+)**	70.9%	83.7%
Ever tested for HIV	59.9%	55.4%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	26.7%	48.2%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

*** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

MAINE

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Maine has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Maine accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Maine accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Maine. Notable findings include:

- For uninsured women in Maine, cost is a major barrier to care—over 43 percent of uninsured women face cost as an obstacle when seeking care, compared to only 13 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 50 percent of uninsured women in Maine receive a recommended mammogram compared to 78 percent of insured women.
- Additionally, only 68 percent of uninsured women receive a recommended Pap test compared to 86 percent of insured women in Maine.

MAINE

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	43.1%	13.4%
Have a personal doctor or health care provider	69.3%	92.5%
Had a "regular checkup" in the last two years	69.0%	89.4%
Had a mammogram in the past two years (aged 40+)**	50.3%	77.7%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	47.4%	74.4%
Had a Pap test in the past three years (18+)**	68.4%	86.0%
Ever tested for HIV***	37.4%	42.8%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	22.4%	46.4%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.
*** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

MISSISSIPPI

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Mississippi has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Mississippi accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Mississippi accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Mississippi. Notable findings include:

- For uninsured women in Mississippi, cost is a major barrier to care—nearly 64 percent of uninsured women face cost as an obstacle when seeking care, compared to only 29 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 41 percent of uninsured women in Mississippi receive a recommended mammogram compared to 73 percent of insured women.
- Uninsured women in Mississippi also fall short of the national average for their rates of mammograms, colon cancer screenings, and flu vaccines.

MISSISSIPPI

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	64.3%	28.6%
Have a personal doctor or health care provider	61.2%	90.4%
Had a "regular checkup" in the last two years	65.2%	89.6%
Had a mammogram in the past two years (aged 40+)**	41.4%	73.1%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	30.0%	59.5%
Had a Pap test in the past three years (18+)**	67.8%	82.8%
Ever tested for HIV***	53.4%	47.8%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	18.0%	35.6%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.
*** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

MISSOURI

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Missouri has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Missouri accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Missouri accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Missouri. Notable findings include:

- For uninsured women in Missouri, cost is a major barrier to care—over 59 percent of uninsured women face cost as an obstacle when seeking care, compared to only 24 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 43 percent of uninsured women in Missouri receive a recommended mammogram compared to 66 percent of insured women.
- Additionally, only 60 percent of uninsured women are receiving a recommended Pap test compared to 77 percent of insured women in Missouri.

MISSOURI

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	58.8%	24.3%
Have a personal doctor or health care provider	53.3%	88.2%
Had a "regular checkup" in the last two years	57.8%	84.8%
Had a mammogram in the past two years (aged 40+)**	43.4%	66.2%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	41.9%	61.8%
Had a Pap test in the past three years (18+)**	60.3%	77.4%
Ever tested for HIV***	52.7%	47.0%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	21.7%	42.3%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

*** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

MONTANA

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Montana has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Montana accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Montana accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Montana. Notable findings include:

- For uninsured women in Montana, cost is a major barrier to care—over 47 percent of uninsured women face cost as an obstacle when seeking care, compared to only 20 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 42 percent of uninsured women in Montana received a recommende mammogram compared to 65 percent of insured women.
- Uninsured women in Montana also fall short of the national average for their rates of mammograms, colon cancer screenings, and cervical cancer screenings.

MONTANA

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	47.3%	20.0%
Have a personal doctor or health care provider	59.6%	77.7%
Had a "regular checkup" in the last two years	52.7%	80.7%
Had a mammogram in the past two years (aged 40+)**	41.5%	65.2%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	32.5%	50.9%
Had a Pap test in the past three years (18+)**	63.3%	76.9%
Ever tested for HIV***	37.6%	40.8%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	23.5%	42.3%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

*** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

NEBRASKA

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Nebraska has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Nebraska accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Nebraska accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Nebraska. Notable findings include:

- For uninsured women in Nebraska, cost is a major barrier to care—nearly 57 percent of uninsured women face cost as an obstacle when seeking care, compared to only 19 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 41 percent of uninsured women in Nebraska receive a recommended mammogram compared to 62 percent of insured women.
- Uninsured women in Nebraska also fall short of the national average for their rates of mammograms and colon cancer screenings.

NEBRASKA

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	56.6%	18.7%
Have a personal doctor or health care provider	66.0%	85.6%
Had a "regular checkup" in the last two years	57.7%	80.6%
Had a mammogram in the past two years (aged 40+)**	40.5%	61.6%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	31.7%	54.1%
Had a Pap test in the past three years (18+)**	65.2%	76.8%
Ever tested for HIV	40.8%	32.9%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	24.1%	42.6%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

NORTH CAROLINA

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but North Carolina has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if North Carolina accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, North Carolina accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in North Carolina. Notable findings include:

- For uninsured women in North Carolina, cost is a major barrier to care—nearly 62 percent of uninsured women face cost as an obstacle when seeking care, compared to only 28 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 49 percent of uninsured women in North Carolina receive a recommended mammogram compared to 77percent of insured women.
- Additionally, only 70 percent of uninsured women receive a recommended Pap test compared to 85percent of insured women in North Carolina.

NORTH CAROLINA

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	61.9%	27.8%
Have a personal doctor or health care provider	54.7%	85.9%
Had a "regular checkup" in the last two years	72.6%	90.5%
Had a mammogram in the past two years (aged 40+)**	49.1%	77.3%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	40.3%	67.1%
Had a Pap test in the past three years (18+)**	70.1%	84.7%
Ever tested for HIV	62.4%	55.1%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	29.1%	44.0%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

OKLAHOMA

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Oklahoma has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Oklahoma accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Oklahoma accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Oklahoma. Notable findings include:

- For uninsured women in Oklahoma, cost is a major barrier to care—over 64 percent of uninsured women face cost as an obstacle when seeking care, compared to only 25 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 28 percent of uninsured women in Oklahoma receive a recommended mammogram compared to 65 percent of insured women.
- Uninsured women in Oklahoma also fall short of the national average for all the health indicators below except flu vaccines.

OKLAHOMA

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	64.4%	24.6%
Have a personal doctor or health care provider	46.7%	81.6%
Had a "regular checkup" in the last two years	52.2%	80.6%
Had a mammogram in the past two years (aged 40+)**	28.1%	64.7%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	28.6%	54.5%
Had a Pap test in the past three years (18+)**	63.4%	76.9%
Ever tested for HIV***	40.4%	43.8%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	26.8%	45.9%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

*** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

SOUTH CAROLINA

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but South Carolina has not yet expanded coverage. This analysis shows that low-income uninsured women— many of whom would be eligible for health insurance if South Carolina accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, South Carolina accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in South Carolina. Notable findings include:

- For uninsured women in South Carolina, cost is a major barrier to care—nearly 65 percent of uninsured women have faced cost as an obstacle when seeking care, compared to only 26 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 51 percent of uninsured women in South Carolina receive a recommended mammogram compared to 75 percent of insured women.
- Uninsured women in South Carolina also fall short of the national average for rates of flu vaccines and cervical cancer screenings.

SOUTH CAROLINA

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	64.6%	26.3%
Have a personal doctor or health care provider	60.1%	85.5%
Had a "regular checkup" in the last two years	64.5%	87.7%
Had a mammogram in the past two years (aged 40+)**	51.2%	75.2%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	38.5%	67.6%
Had a Pap test in the past three years (18+)**	67.4%	83.4%
Ever tested for HIV***	51.0%	47.4%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	20.9%	37.0%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

*** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

SOUTH DAKOTA

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but South Dakota has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if South Dakota accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, South Dakota accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in South Dakota. Notable findings include:

- For uninsured women in South Dakota, cost is a major barrier to care—over 51 percent of uninsured women face cost as an obstacle when seeking care, compared to only 22 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 50 percent of uninsured women in South Dakota receive a recommended mammogram compared to 74 percent of insured women.
- Uninsured women in South Dakota also fall short of the national average for rates of HIV screenings, colon cancer screenings, and cervical cancer screenings.

SOUTH DAKOTA

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	51.3%	22.4%
Have a personal doctor or health care provider	63.1%	73.4%
Had a "regular checkup" in the last two years	62.1%	83.8%
Had a mammogram in the past two years (aged 40+)**	50.0%	73.8%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	29.3%	56.3%
Had a Pap test in the past three years (18+)**	68.9%	82.3%
Ever tested for HIV***	38.5%	39.5%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	32.6%	53.3%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

*** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

TENNESSEE

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Tennessee has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Tennessee accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Tennessee accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Tennessee. Notable findings include:

- For uninsured women in Tennessee, cost is a major barrier to care—over 57 percent of uninsured women face cost as an obstacle when seeking care, compared to only 25 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 42 percent of uninsured women in Tennessee receive a recommended mammogram compared to 73 percent of insured women.
- Uninsured women in Tennessee also fall short of the national average for rates of mammograms and colon cancer screenings.

TENNESSEE

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	57.1%	25.1%
Have a personal doctor or health care provider	51.6%	85.3%
Had a "regular checkup" in the last two years	70.3%	93.7%
Had a mammogram in the past two years (aged 40+)**	41.9%	72.8%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	36.9%	67.7%
Had a Pap test in the past three years (18+)**	65.6%	82.4%
Ever tested for HIV***	44.0%	53.7%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	33.1%	49.6%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

*** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

TEXAS

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Texas has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Texas accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Texas accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Texas. Notable findings include:

- For uninsured women in Texas, cost is a major barrier to care—nearly 60 percent of uninsured women face cost as an obstacle when seeking care, compared to only 30 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 43 percent of uninsured women in Texas receive a recommended mammogram compared to 71 percent of insured women.
- Uninsured women in Texas also fall short of the national average for rates of mammograms, colon cancer screenings, and flu vaccines.

TEXAS

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	59.8%	30.2%
Have a personal doctor or health care provider	39.2%	81.9%
Had a "regular checkup" in the last two years	66.2%	86.5%
Had a mammogram in the past two years (aged 40+)**	43.3%	71.4%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	30.7%	62.5%
Had a Pap test in the past three years (18+)**	67.7%	80.8%
Ever tested for HIV***	44.9%	47.0%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	22.1%	39.4%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

*** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

UTAH

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Utah has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Utah accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Utah accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Utah. Notable findings include:

- For uninsured women in Utah, cost is a major barrier to care—over 57 percent of uninsured women face cost as an obstacle when seeking care, compared to only 26 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 35 percent of uninsured women in Utah receive a recommended mammogram compared to 66 percent of insured women.
- Uninsured women in Utah also fall short of the national average for rates of HIV screenings, cervical cancer screenings, and mammograms.

UTAH

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	57.2%	26.0%
Have a personal doctor or health care provider	58.7%	81.0%
Had a "regular checkup" in the last two years	56.7%	80.5%
Had a mammogram in the past two years (aged 40+)**	34.5%	65.7%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	39.8%	67.1%
Had a Pap test in the past three years (18+)**	63.5%	71.8%
Ever tested for HIV	42.1%	35.8%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	20.6%	38.5%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

VIRGINIA

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Virginia has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Virginia accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Virginia accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Virginia. Notable findings include:

- For uninsured women in Virginia, cost is a major barrier to care—over 62 percent of uninsured women face cost as an obstacle when seeking care, compared to only 23 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 52 percent of uninsured women in Virginia receive a recommended mammogram compared to 76 percent of insured women.
- Uninsured women in Virginia also fall short of the national average for rates of cervical cancer screenings.

VIRGINIA

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	62.0%	23.1%
Have a personal doctor or health care provider	60.1%	84.0%
Had a "regular checkup" in the last two years	70.0%	88.4%
Had a mammogram in the past two years (aged 40+)**	52.1%	76.3%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	35.8%	70.7%
Had a Pap test in the past three years (18+)**	69.4%	81.5%
Ever tested for HIV	57.2%	46.6%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	24.6%	43.0%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

WYOMING

Under the Affordable Care Act (ACA), states may expand eligibility for their Medicaid programs to provide health coverage for millions of low-income Americans, but Wyoming has not yet expanded coverage. This analysis shows that low-income uninsured women—many of whom would be eligible for health insurance if Wyoming accepted the federal money to expand Medicaid coverage—are more likely to go without care because of cost, less likely to have a regular source of care, and utilize preventive services at lower rates than low-income women with health insurance. In short, this population is in dire need of affordable health coverage in order to access the care they need to get and stay healthy.

Women will continue to suffer from limited access to care if they remain in the coverage gap between today's Medicaid program and the new coverage of the ACA. If, however, Wyoming accepts this federal money and expands coverage through Medicaid, thus eliminating the coverage gap, the state would ensure that all low-income women can access the care they need to lead healthier lives.

The data below reflect the health care gap between insured and uninsured low-income women in Wyoming. Notable findings include:

- For uninsured women in Wyoming, cost is a major barrier to care—nearly 57 percent of uninsured women face cost as an obstacle when seeking care, compared to only 22 percent of insured women.
- Uninsured women utilize preventive services at lower rates; only 29 percent of uninsured women in Wyoming receive a recommended mammogram compared to 59 percent of insured women.
- Uninsured women in Wyoming also fall short of the national average for rates of mammograms, HIV screenings, and cervical cancer screenings.

WYOMING

Indicator	Low-Income Women without Insurance	Low-Income Women with Insurance
In the last 12 months, have needed to see a doctor but could not because of cost*	56.5%	21.5%
Have a personal doctor or health care provider	64.4%	80.1%
Had a "regular checkup" in the last two years	53.9%	80.1%
Had a mammogram in the past two years (aged 40+)**	29.1%	59.2%
Had a sigmoidoscopy or colonoscopy (aged 50+)**	32.7%	58.3%
Had a Pap test in the past three years (18+)**	58.9%	74.2%
Ever tested for HIV***	37.5%	39.3%
In the last 12 months, have had either a seasonal flu shot or a seasonal flu vaccine that was sprayed through the nose	24.7%	39.2%

* For this question alone, a higher percentage means that fewer women are accessing care.
** These questions are based on BRFSS data from 2012.

*** The difference between the two groups in not statistically significant.

Source: NWLC analysis of the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Data (BRFSS), 2014, available at http://www.cdc.gov/brfss/index.htm

NATIONAL WOMEN'S LAW CENTER
www.nwlc.org

endnotes

1 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001 (2010), amended by Health Care and Education Affordability and Reconciliation Act, Pub. L. No. 111-152 (2010).

2 The traditional Medicaid program is also optional to the states and it took 18 years from passage for all states to opt in.

3 This reflects the number of states that had expanded Medicaid coverage as of October 8, 2014. The state of Indiana submitted a waiver request to HHS in order to expand Medicaid coverage but at the time of this report, the waiver has not yet been approved.

4 Wisconsin has not accepted federal funds to expand Medicaid coverage under the ACA, but the state amended its Medicaid program to cover adults up to 100% FPL in Medicaid so there is no coverage gap for women. In this report, we do not include Wisconsin in our count.

5 Genevieve M. Kenney et. al., The Urban Institute, Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage, (August 2012), available at http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

6 Elizabeth M. Patchias & Judy Waxman, "Women and Health Coverage, the Affordability Gap," National Women's Law Center, (April 2007), available at http://www.commonwealthfund.org/usr_doc/1020_Patchias_women_hlt_coverage_affordability_gap.pdf.

7 Alina Salganicoff and Usha Ranji, Kaiser Family Foundation, "Women and Health Care in the Early Years of the ACA: Key Findings from the 2013 Kaiser Women's Health Survey" (May 2014) available at http://kff.org/womens-health-policy/report/women-and-health-care-in-the-early-years-of-the-aca-key-findings-from-the-2013-kaiser-womens-health-survey/.

8 Evelyn Whitlock, et al. "Liquid-Based Cytology and Human Papillomavirus Testing to Screen for Cervical Cancer, A Systematic Review for the U.S. Preventive Services Task Force," (October 2011), available at http://www.uspreventiveservicestaskforce.org/uspstf11/cervcancer/cervcancerupd.htm.

9 Katherine Baicker, Ph.D., and Amy Finkelstein, Ph.D., "The Effects of Medicaid Coverage — Learning from the Oregon Experiment," The New England Journal of Medicine 365 (2011): 683-685, available at http://www.nejm.org/doi/full/10.1056/NEJMp1108222.

10 Kaiser Family Foundation, "States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid" (July 2014) available at http://kff.org/medicaid/state-indicator/family-planning-services-waivers/#.

11 In order to present standardized data for this report, we combined certain response categories originally offered in BRFSS. For example, there were several available responses for the question asking about the respondent's last check-up. To present the responses in two categories, we grouped respondents who said their last visit was "within past 2 years" or "2 years or more." All analysis excluded respondents who did not know the answer or refused to answer.

11 Dupont Circle, Suite 800
Washington, DC 20036
202.588.5180 | fax 202.588.5185
www.nwlc.org