Georgetown University
Health Policy Institute
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Medicaid Expansion Narrows Maternal Health Coverage Gaps, But Racial Disparities Persist

by Maggie Clark, Ema Bargeron, and Alexandra Corcoran

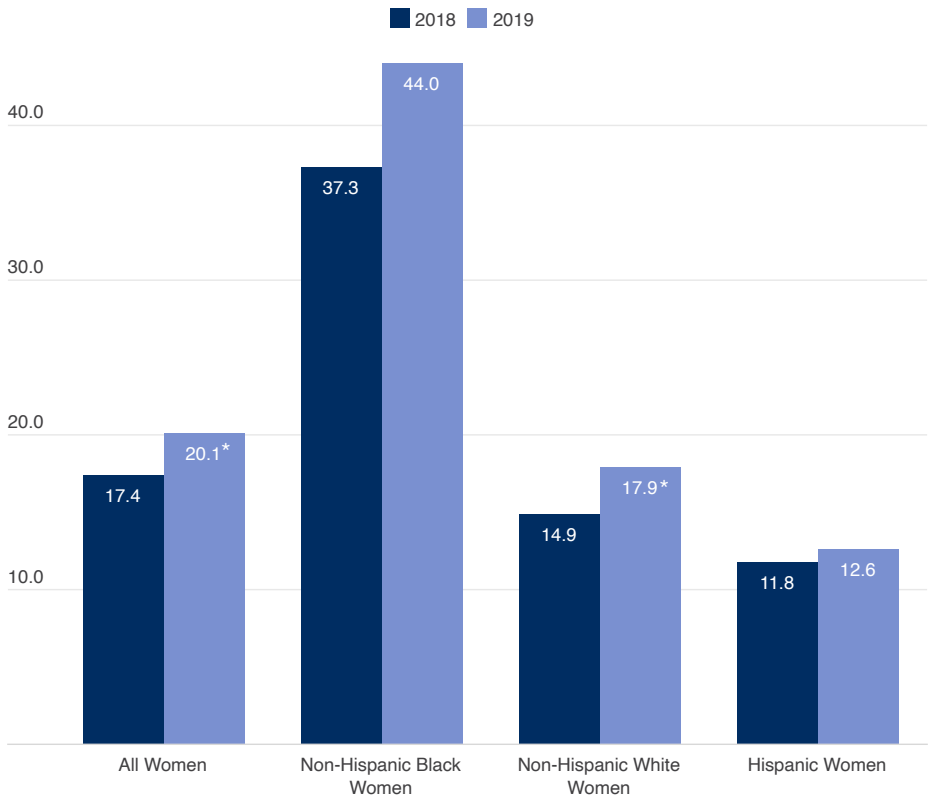
- **The U.S. has the highest maternal mortality rate of any industrialized country and the crisis is getting worse.**[1] The burden weighs heaviest on Black women, who are more than twice as likely to die of pregnancy-related causes than the national average rate for all women, regardless of education level or other socioeconomic factors.[2] The majority of these deaths are preventable.[3]
- A state's decision on whether to expand Medicaid has a profound effect on women of childbearing age.[4] **Women of childbearing age (age 18-44) who lived in non-expansion states were more than twice as likely to be uninsured (19 percent) than women living in states that had expanded Medicaid (9.2 percent) in 2019, and the trend extended across all racial and ethnic groups.**
- **Medicaid expansion is associated with lower rates of maternal and infant mortality, with the greatest benefits for Black women and infants, studies have shown.**[5] Expansion has also been associated with improvements in preconception health and utilization of preventive care, and supporting healthy development of parents and children together.[6]
- **In the years following the ACA coverage expansions, the United States made significant progress in reducing the uninsured rate for women of childbearing age and reached a historic low of 12.3 percent uninsured in 2016.** But the nation changed course and the rate significantly increased to 12.8 percent by 2019. There were 384,000 more uninsured women of childbearing age in 2019 than in 2016. In 2019, 7.5 million women of childbearing age were uninsured.
- **Wide disparities in coverage persist between racial and ethnic groups within states, both in states that have expanded Medicaid and in states that have not.** Women who identified as Hispanic/Latina in non-expansion states have the highest uninsured rates of any racial or ethnic group, with more than one-third, or 35.5 percent, reporting being uninsured in 2019 (see Table 1).[7]

Introduction

The United States is experiencing a maternal mortality crisis and has the highest maternal mortality rate of any industrialized country in the world.[8] In 2019, more than 750 women died of maternal causes in the United States while pregnant or within 42 days after the end of pregnancy, data from the Centers for Disease Control and Prevention shows.[9] The maternal mortality rate in 2019 for all women, at 20.1 deaths per 100,000 live births, was significantly higher than the rate for 2018, at 17.4 deaths per 100,000 live births (see Figure 1).[10] The 2019 maternal mortality rate was the highest rate recorded by the CDC since the agency began tracking pregnancy-related mortality more than 30 years ago.[11]

Disaggregating the data by race, Black women had the highest maternal mortality rates of any group in 2019 (44 deaths per 100,000 live births), which was 2.5 times the rate for non-Hispanic white women and 3.5 times the rate for Hispanic women, the data showed.[12] Previously between 2014 and 2017, Black women and American Indian/Alaska Native women consistently experienced the highest maternal mortality rates of any racial groups, which the CDC reports may be due to several factors, including structural racism and implicit biases.[13] For instance, Black and American Indian/Alaska Native women are more likely to live in areas with limited access to maternity care, known as "maternity care deserts," and report consistent experiences of racism while interacting with the health care system.[14]

Figure 1. Change in Maternal Mortality Rate, 2018-2019



Rate is equivalent to the number of maternal deaths per 100,000 live births by women of given group.

** Indicates that change is significant at the 95% confidence level relative to the prior year indicated.*

Source: Georgetown CCF visualization of Hoyert, D.L. "Maternal Mortality Rates in the United States, 2019," NCHS Health E-Stats (April 2021), available at https://doi.org/10.15620/cdc:103855.

These accumulated experiences of racism can contribute to toxic, unrelenting stress, which can interrupt the function of the immune, endocrine, and nervous systems, leading to chronic inflammation in the body.[15] Among pregnant women, the effects of this toxic stress are felt by mothers and babies alike: multiple studies have shown that women who experienced racism and discrimination were more likely to have an infant born at low or very low birth weight.[16]

While no one policy change can solve this crisis, Medicaid expansion is an effective strategy that has been shown to support the health of women of childbearing age and their children, with the greatest benefits for women and infants of color. Research shows that Medicaid expansion is significantly associated with seven fewer maternal deaths per 100,000 live births relative to non-expansion states, with the greatest decreases in mortality rates among Black, non-Hispanic women and Hispanic women.[17] Medicaid expansion has also been linked to declines in infant mortality, with the steepest declines for Black babies.[18]

Medicaid Expansion Coverage for Parents is Good for Children Too

Medicaid expansion is an essential strategy to improve infant and child health and wellbeing.[19]

Children born to Medicaid-covered parents are more likely to be born at a healthier birth weight, have greater health care utilization later in childhood, and are at lower risk of infant mortality than babies born to women who are uninsured.[20] Medicaid expansion for adults had a measurable "welcome mat" effect for children, increasing coverage rates among children who were likely already eligible but not enrolled.[21]

Data show that declines in infant mortality between 2010 and 2016 were 50 percent greater for infants born in states that had expanded Medicaid than states that had not, and Black babies experienced the greatest benefits.[22] Medicaid expansion also increased the likelihood that infants are born to households where their parents have health coverage, another study found.[23] Children with parents who have health insurance are more likely to have access to preventative health care, such as regular well child visits.[24]

Expansion has also been shown to reduce racial disparities for infants in health outcomes, including in preterm birth, very preterm birth, low birth weight, and very low birth weight.[25]

In addition to physical health, parents who live in Medicaid expansion states are also more likely to report better communication with and overall warmth towards their children, providing evidence that Medicaid expansion can improve how parents interact with their children, largely due to reduced stress.[26] Families living in non-expansion states also had higher medical debts than families in expansion states on average, which contributes to family stress and financial hardship.[27]

Expansion has also been associated with reductions in reported child neglect rates, and expanded coverage supports parents experiencing depression, which if left untreated may cause developmental delays and behavioral challenges for the child.[28,29] Research has shown that rates of anxiety and depression in caregivers have increased dramatically since the onset of the COVID-19 pandemic, signaling more support for parents, especially in non-expansion states, is urgently needed.[30]

Researchers have found that Medicaid expansion is also associated with greater access to and utilization of health care by women of childbearing age, and the health benefits extend to their children as well.[31] States also have an important new state plan amendment option in Medicaid to extend postpartum coverage for one year after the end of pregnancy, which will further support access to ongoing postpartum and inter-conception care that women need to support their long-term health and the health of future pregnancies.

The COVID-19 pandemic has further exposed the vast inequities experienced by low-income young women and parents, many of whom work in low-wage jobs that have put them at increased risk of contracting COVID-19.[32] Many have faced tremendous stress due to caregiving responsibilities, job loss, loss of loved ones and other pandemic-related hardships.[33]

Added to the heavy load of structural racism that has affected the health of women and infants of color for generations, the current crisis has underscored the need for comprehensive strategies to close the coverage gaps that exist for women in non-expansion states, as well as to address racial disparities in coverage and health outcomes that persist in all states.[34]

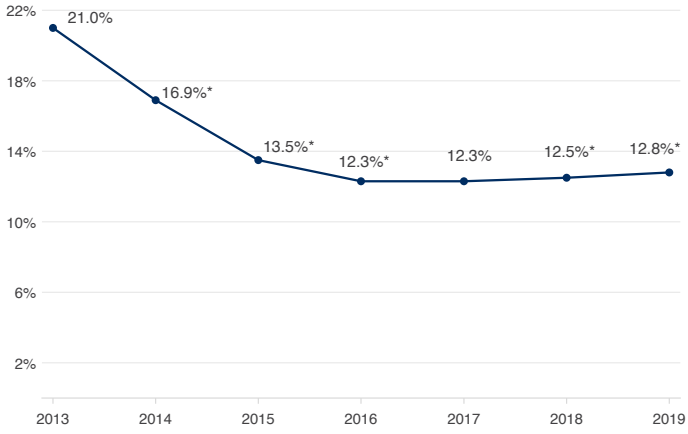
Expanding Medicaid is an essential policy step for state and federal policymakers seeking to ensure that all people, regardless of where they live or what they earn, have the support they need to take care of themselves and their growing families before, during, and after pregnancy.

Medicaid Expansion Leads to Reduced Uninsured Rates for Women of Childbearing Age

Since the ACA's Medicaid expansion first took effect, the uninsured rate for all women of childbearing age has dropped from 21.0 percent in 2013 to 12.8 percent in 2019. The data show that the uninsured rate for all women of childbearing age reached a historic low of 12.3 percent by 2016, but increased significantly by 2019 (see Figure 2). This alarming trend mirrors national increases in the uninsured rate for children and all adults over the same period during the Trump Administration.[35]

Uninsured rates in all states declined quickly after the ACA's coverage expansions began in 2014, due to the ACA's "welcome mat effect" and the new availability of Marketplace coverage.[36] But states that expanded Medicaid saw the steepest declines in the uninsured rate for women of childbearing age. The 11 states with the largest declines expanded Medicaid. New Mexico, West Virginia, and Kentucky saw decreases of more than 15 percentage points in the uninsured rate during this period (see Figure 3).

Figure 2. Annual Uninsured Rate for Women of Childbearing Age (18-44), 2013-2019

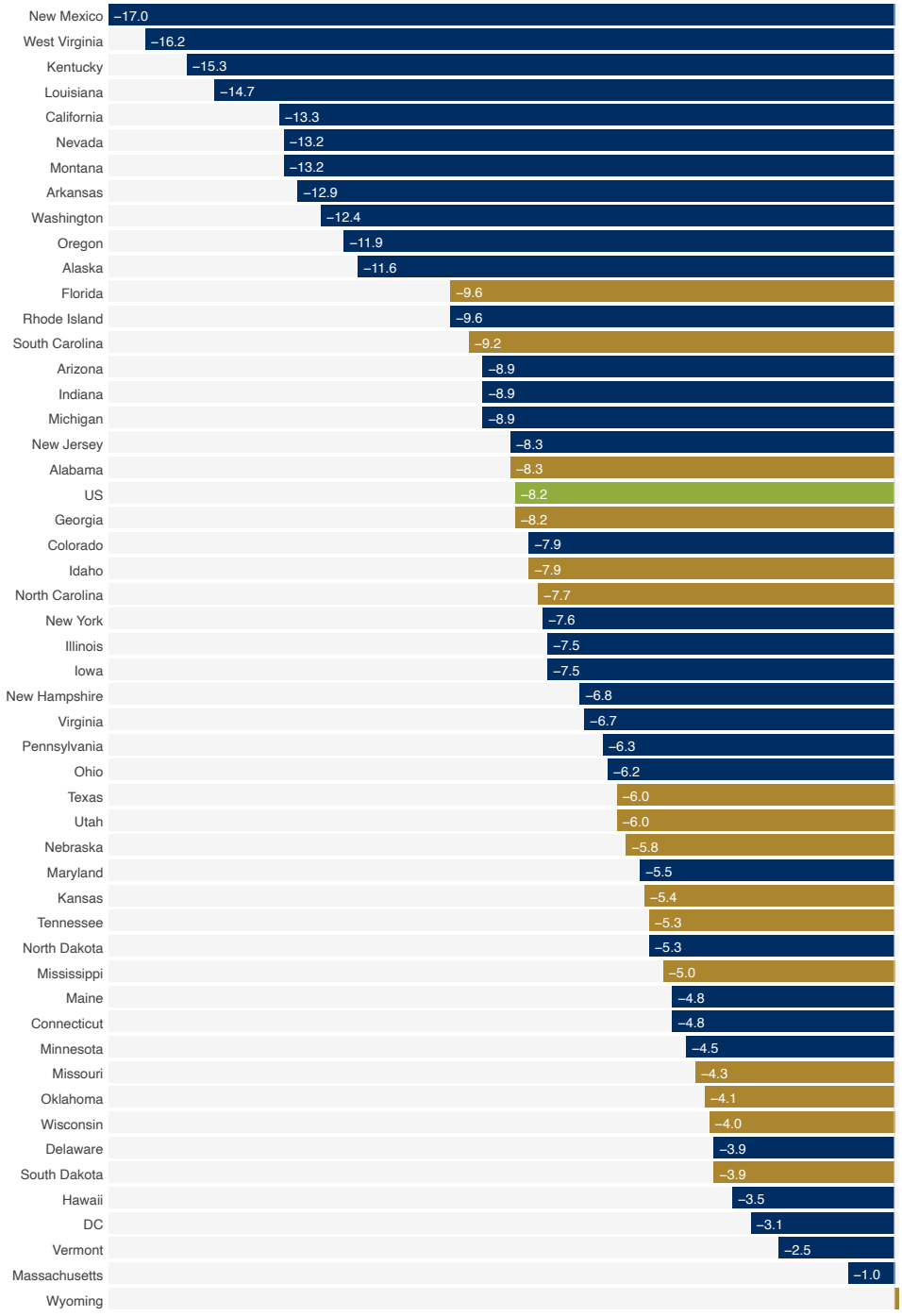


** Indicates that change is significant at the 90% confidence level relative to the prior year indicated.*

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau American Community Survey (ACS) 2013-2019 Public Use Microdata Sample (PUMS).

> *"States that expanded Medicaid saw the steepest declines in the uninsured rate for women of childbearing age."*

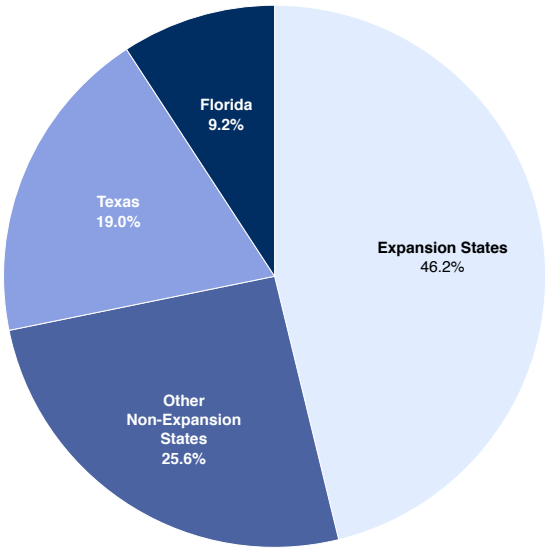
Figure 3. Percentage Point Change in Uninsured Rate for Women of Childbearing Age (18-44), 2013-2019



Seven states (Alaska, Indiana, Louisiana, Maine, Montana, Pennsylvania, and Virginia) implemented Medicaid expansion between December 2014 and January 2019. Expansion states are designated as such if enrollment began by the start of 2019. Idaho, Utah, and Nebraska implemented Medicaid expansion during calendar year 2020. Oklahoma began implementing expansion in 2021 and Missouri will implement the expansion later this year.

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau American Community Survey (ACS) 2013-2019 Public Use Microdata Sample (PUMS).

Figure 4. A Disproportionate Share of Uninsured Women of Childbearing Age (18-44) Live in Non-Expansion States



Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau American Community Survey (ACS) 2019 Public Use Microdata Sample (PUMS).

The 17 states that had not expanded Medicaid to all adults by 2019 were home to a disproportionate share of uninsured women of childbearing age. More than half of the 7.5 million uninsured women of childbearing age—53.8 percent—lived in the 17 states that had not expanded Medicaid by 2019. Roughly one out of every four uninsured women of childbearing age in 2019 lived in either Texas or Florida (see Figure 4).

Women of childbearing age who lived in non-expansion states were more than twice as likely to be uninsured (19 percent) than women living in states that had expanded Medicaid (9.2 percent) in 2019, and the trend extended to all racial and ethnic groups (see Table 1). For instance, a Black woman in Texas, a non-expansion state, had an uninsured rate (21.4 percent) more than double the the average rate for Black women living in expansion states (9.0 percent) (see Table 2 in online chartbook).

Table 1. Disparities in Uninsured Rates for Women of Childbearing Age (18-44) by Expansion Status and Demographics, 2019

	Uninsured Rate: Expansion States	Uninsured Rate: Non-Expansion States	Women in Non-Expansion States are X Times More Likely to be Uninsured
Race			
American Indian/Alaska Native	19.9%	31.1%*	More than 1.5x
Asian/Native Hawaiian/Pacific Islander	6.8%	11.3%*	More than 1.5x
Black/African American	9.0%	18.2%*	2x
Other	16.3%	32.9%*	2x
White	8.3%	18.2%*	More than 2x
Ethnicity			
Hispanic/Latina	17.7%	35.5%*	2x
Not Hispanic/Latina	7.0%	14.6%*	More than 2x

Note: "Other" category includes those who identify as "two or more races" or "some other race." The American Community Survey measures race and ethnicity as two separate facets of an individual's identity. Hispanic/Latino individuals can be of any race.

** Indicates that change is significant at the 90% confidence level relative to the category indicated.*

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau American Community Survey (ACS) 2019 Public Use Microdata Sample (PUMS).

Women who identified as Black, white, or "two or more races/some other race," or Hispanic/Latina all had at least 50 percent higher uninsured rates in states that had not expanded Medicaid, compared to women who identified in the same racial and ethnic groups but who lived in states that had expanded (see Table 1).

However, wide disparities in uninsured rates between racial and ethnic groups persist within states whether a state has expanded Medicaid or not. The data make clear that Medicaid expansion must be the first step for states working to address maternal health inequities, but all states can do more to address racial disparities in health coverage and outcomes for women of childbearing age and their families.

States Rejecting Medicaid Expansion are Missing an Opportunity to Improve Maternal Health

Medicaid expansion is especially important to the health of Black women and people of color in their childbearing years. In non-expansion states, more than two-thirds of uninsured childbearing-age women who had an income below 138 percent of the poverty level identified as women of color or Hispanic/Latina (68.5 percent in 2019).[37] Women who identify as Hispanic/Latina and who live in non-expansion states have the highest uninsured rates of any racial or ethnic group, with more than one-third, or 35.5 percent, of women reporting being uninsured in 2019 (see Table 1).

For low-income women who live in the 12 states without Medicaid expansion, their options for coverage are limited. Income eligibility levels for parents are very low, with a median of 40 percent, or about $8,800 per year for a family of three (See Figure 6).[38]

Outside of parent coverage, most low-income women in non-expansion states may only enroll in Medicaid or CHIP coverage after they become pregnant. This coverage includes prenatal care and labor and delivery, and ends just 60 days after the end of the pregnancy.[39] Medicaid financed about 42 percent of births in 2019, and a greater share of births in rural areas, among young women, and for women of color.[40] State eligibility levels for pregnancy-related Medicaid coverage vary dramatically, but the average eligibility level for pregnancy coverage is 200 percent of the federal poverty level (FPL), or about $43,440 per year for a family of three.[41, 42] States can also choose to use their CHIP programs to cover certain higher-income pregnant and postpartum women, or women ineligible due to immigration status.[43]

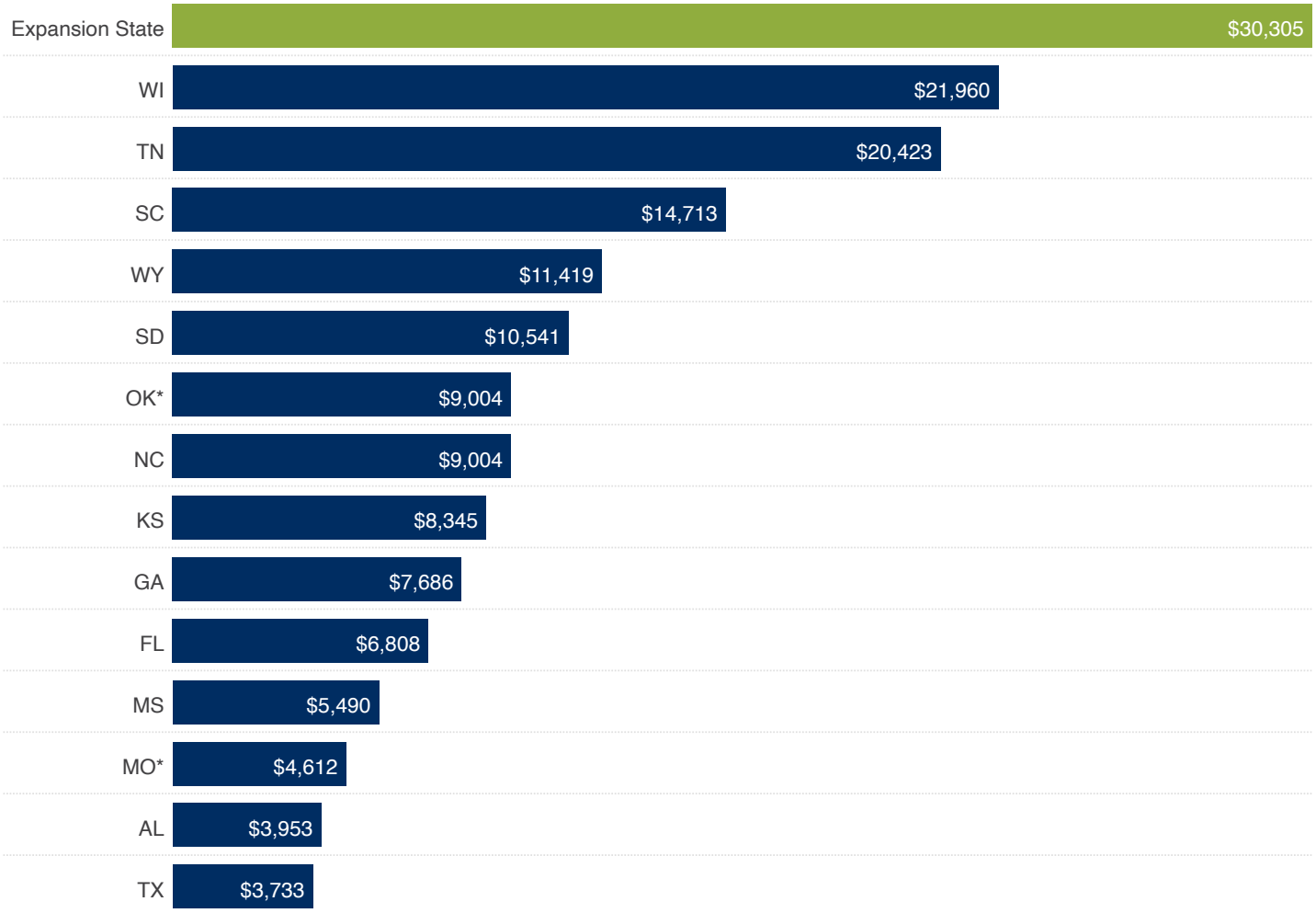
Federal Action to Close the Coverage Gap

Simply expanding Medicaid at the state level is the fastest and best way to reach an estimated 4.3 million people with comprehensive, affordable health coverage. However, despite the clear benefits of Medicaid expansion and extremely generous federal funding, state politics continue to present a barrier to adopting Medicaid expansion in the 12 remaining states.

Federal policymakers are currently considering several alternatives to Medicaid expansion that would close the coverage gap in those states and be fully federally administered. For example, Congress is considering a plan to create a permanent and comprehensive pathway to coverage for those left behind.[44]

However, it may take time for Congress to act and for the Administration to implement such a federal fallback program, whereas Medicaid expansion is an option available now. State and federal policymakers have a responsibility to act now to expand Medicaid and reduce coverage disparities for women of childbearing age.

Figure 5. Medicaid Parent Eligibility Levels in Non-Expansion States



**Oklahoma voters approved Medicaid ballot expansion measures in June 2020 and an expansion state plan amendment was approved in December 2020. Medicaid expansion implementation began in 2021. Missouri voters approved a Medicaid ballot expansion measure in August 2020. After litigation, the state began accepting applications from expansion beneficiaries in August.*

Source: Brooks, T. et al., "Medicaid and CHIP Eligibility and Enrollment Policies as of January 2021: Findings from a 50-State Survey," Georgetown University Center for Children and Families and the Kaiser Family Foundation, March 2021, https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-and-Enrollment-Policies-as-of-January-2021-Findings-from-a-50-State-Survey.pdf.

Lack of Coverage Can Contribute to Causes of Maternal Mortality

After the postpartum period ends, most women living in states without Medicaid expansion no longer have access to coverage, leaving them without a connection to ongoing health care at a time when they are still recovering from pregnancy complications that can be deadly. Cardiovascular conditions, in addition to other common complications such as gestational diabetes and preeclampsia, are increasing among women and are often the result of years of health and social challenges which cannot be managed by just a couple of months of prenatal care alone.[45,46]

Drug overdose and suicide, two other frequent causes of death within the first year after birth, are often driven by untreated perinatal mood and anxiety disorders, which affect one in seven pregnant and postpartum women nationwide, and are reported to affect between 40 and 60 percent of new mothers with low incomes.[47,48] These conditions affect the health of both mothers and children, who miss out on important bonding experiences and may struggle to reach behavioral and developmental milestones.[49] Researchers estimated that untreated perinatal mood and anxiety disorders cost about $14.2 billion for mother and child pairs in the five years after their births in 2017, due to factors including lower workforce participation, increased risk of preterm birth, and developmental delays for children later in life.[50]

State maternal mortality review data have consistently shown that a significant portion of pregnancy-related deaths occur between two months and one year after the end of the pregnancy, after postpartum Medicaid coverage has expired for many postpartum women.[51] These late maternal deaths are 3.5 times more likely among Black women than white women, researchers found in a review of maternal death records from 2016 and 2017.[52] Postpartum cardiomyopathy, a form of congestive heart failure, was the leading overall cause of late maternal deaths, with Black women having a six-times-higher risk than white women, the study showed.

Medicaid expansion ensures that low-income women can be covered before, during, and after pregnancy so they can start their pregnancies in better health and receive the ongoing treatment they need for any chronic health challenges that can be exacerbated by pregnancy. In a study comparing the effects of Medicaid expansion on postpartum coverage and outpatient utilization, researchers found that among people with severe pregnancy-related health conditions, postpartum visits in Colorado (which expanded Medicaid) were 50 percent higher than in Utah (which had not expanded Medicaid at the time the study was conducted).[53] Postpartum uninsured rates among women who were covered by Medicaid at the end of pregnancy were three times lower in expansion states than in non-expansion states, another study found.[54]

As part of the American Rescue Plan, which became law in early 2021, states now have the option to extend postpartum coverage in Medicaid and CHIP to one year after the end of pregnancy. This important new option provides federal matching funds for states to offer an additional 10 months of coverage to provide access to important services, such as substance use disorder treatment, chronic disease management and mental health counseling, that can address the causes of maternal mortality and set women on a path for long term health.

There have been 16 states so far that have already appropriated funds to take up the option as soon as it becomes available on April 1, 2022.[55] However, extending postpartum coverage in a state that has not adopted Medicaid expansion does not remove the structural barrier to comprehensive coverage that supports women's access to care throughout their life. Extending postpartum Medicaid in a non-expansion state is a critical first step, but to fully maximize the option's potential to address the causes of maternal mortality and morbidity, extended postpartum Medicaid should build on Medicaid expansion's foundation to ensure that every family has the health coverage they need in this critical period.[56]

> *"Medicaid expansion ensures that low-income women can be covered before, during, and after pregnancy."*

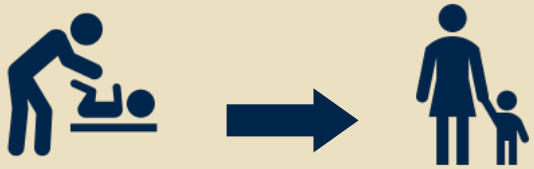
Extending Postpartum Medicaid Coverage for One Year After Pregnancy

Medicaid coverage provides access to essential prenatal and labor and delivery care for thousands of women each year, yet it does not provide coverage before pregnancy and the coverage period ends just 60 days after the end of pregnancy. This cutoff requires new parents to find new insurance coverage while caring for a newborn and managing their own postpartum health needs. Many low-income women lose coverage altogether at this vulnerable time, and the coverage loss rates are higher in states that have not expanded Medicaid.[57]

To address the problem, Congress created a Medicaid state plan amendment to allow states to extend postpartum coverage for one year after the end of pregnancy and receive federal matching funds. The option, created under the American Rescue Plan Act (ARPA), will be available starting April 1, 2022, allowing states to provide 12 months of full benefits to all postpartum people who are covered by Medicaid for pregnancy.[58] The benefits must extend for 12 months postpartum and be available to all postpartum people– not just for a subgroup of postpartum people or for a shorter period of time. States receive their regular Medicaid matching rate (federal medical assistance percentage, FMAP) for the extended coverage period and the option sunsets after five years.

Since passage of ARPA in March 2021, there have been 16 states—both expansion and non-expansion—that have so far allocated money to take up the option and begin offering extended coverage when it becomes available in April 2022.[59] Three additional states (Illinois, Georgia, Missouri) have also been approved by CMS to extend postpartum coverage in a more limited set of circumstances through a section 1115 demonstration.[60]

Creating a new standard of 12 months of postpartum Medicaid coverage is an undoubtedly important step to provide new mothers with better access to care during a critical period. But extended postpartum coverage does not make up for the fact that low-income adults in states that have not expanded Medicaid do not have access to coverage before or after pregnancy. Lawmakers in several non-expansion states, including Texas, Florida, Georgia, and Tennessee, have allocated funding for the extended postpartum coverage option, yet they continue to refuse to expand Medicaid to all adults.



2 months 12 months

The creation of the extended postpartum Medicaid and CHIP coverage option is an important down payment to support maternal and infant health.

These states are also rejecting billions more in new federal incentives from ARPA to expand Medicaid.[61] States that newly expand Medicaid receive an added incentive for their traditional Medicaid population: an additional five-percentage point increase in the regular FMAP for two years, no matter when they adopt and implement expansion (the FMAP for the expansion population remains 90 percent).[62] The Kaiser Family Foundation estimates that if all 12 non-expansion states expand in 2022, they would receive a net overall gain of $9.6 billion in federal funds.[63]

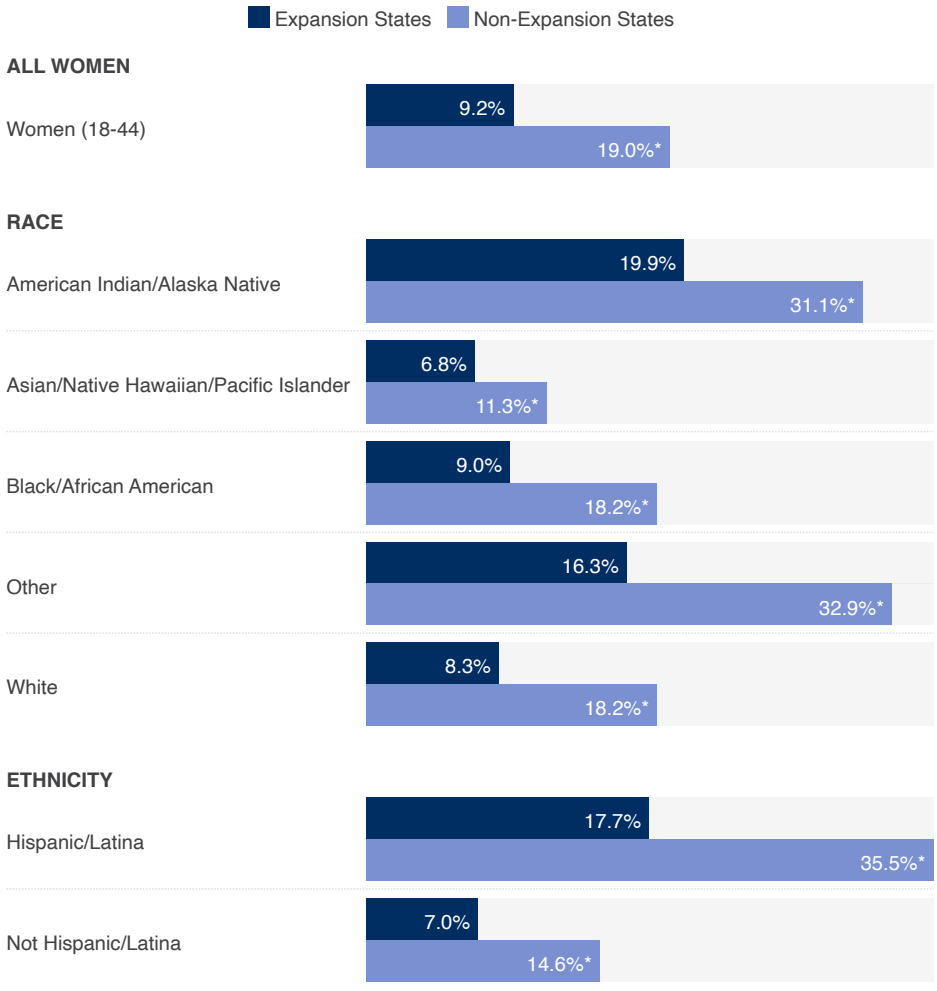
Extending postpartum Medicaid coverage for one year after the end of pregnancy builds on Medicaid expansion's foundation to ensure continuity of care for moms and babies at a critical time.

Persistent Racial Disparities in Coverage and Care Need Focused Attention

Women of childbearing age are twice as likely to be uninsured in non-expansion states, but when disaggregating the data by race and ethnicity, it is clear that racial and ethnic disparities in coverage rates persist within all states. Regardless of a state's expansion status, American Indian/Alaska Native women and women who identify as "other" race are about twice as likely to be uninsured as women who identify as white or Black/African American (see Figure 6). Importantly, demographers have documented that people who select their race as "Other" in the Census are often Hispanic or Latina, and choose the "Other" category because they do not identify as white or Black.[64] This aligns with data showing that women of childbearing age who identify Hispanic/Latina as their ethnicity on the American Community Survey, both in expansion and non-expansion states, have higher uninsured rates than women who select non-Hispanic/Latina.[65]

These coverage disparities are stark. For instance, the state-level data shows that in Maryland and Minnesota, which have both expanded Medicaid, each state has an overall uninsured rate for women of childbearing age well below the national average, at 8.4 percent and 6.4 percent uninsured respectively.

Figure 6. Uninsured Rate for Women of Childbearing Age (18-44), 2019



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Note: "Other" category includes those who identify as "two or more races" or "some other race." The American Community Survey measures race and ethnicity as two separate facets of an individual's identity. Hispanic/Latino individuals can be of any race.

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau American Community Survey (ACS) 2019 Public Use Microdata Sample (PUMS).

Yet in both states, Hispanic/Latina women had much higher uninsured rates than women who identified as non-Hispanic in 2019—five times as high in Maryland and four times as high in Minnesota. In Tennessee and Wisconsin, which have not expanded Medicaid and have higher overall uninsured rates, women of childbearing age had similarly wide disparity gaps (see Appendix B).

When comparing racial groups, Black and white women's average uninsured rates are within one point of each other in expansion states (see Table 1), yet Black women are still much more likely to die of a pregnancy-related cause than white women in those states. For instance, in New Jersey, Black women have an 11 percent uninsured rate compared to 10 percent for white women (see Appendix A), yet *Black women in New Jersey are seven times more likely than white women to die of a pregnancy-related cause.*[66]

This reality underscores the role of racism and discrimination in health care that studies show can lead patients to avoid or delay seeking care, be misdiagnosed, or receive inappropriate treatment.[67] To address the harms of racism in health care and better serve women of color before, during, and after pregnancy, some states are making changes in Medicaid and throughout their health care systems to promote antiracist, respectful maternity care.[68]

Among the options some states are pursing are additional benefits, such as group prenatal care, evidence-based home visiting programs and substance-used disorder services tailored specifically for pregnant and postpartum people, as well as extending postpartum Medicaid coverage through the American Rescue Plan option for one year after the end of pregnancy.[69,70]

Medicaid managed care contract requirements are another lever states can use to make change.[71] For instance, as part of Michigan's Mother Infant Health and Equity Improvement Plan, the state now requires all Medicaid managed care plans operating in the state to participate in a performance improvement project to work together in each region to reduce the rate of babies born at low birth weight.[72] The state also requires all managed care plans to report selected quality metrics by race and develop an annual health equity plan to narrow disparities.[73]

States are also looking at policies to better incorporate care from community-based providers such as doulas, community health workers, or peer navigators to provide more direct, culturally competent services to women throughout their childbearing years.[74] [75] Several states have recently added doula care as a benefit to women who are covered by Medicaid for pregnancy, which includes non-medical services provided to women and people who give birth throughout the prenatal, birth, and postpartum period.[76] Research has shown that women covered by Medicaid who have prenatal access to doula care had lower rates of preterm birth and caesarean section delivery than other women in their region, both improving health outcomes and saving money for the state Medicaid program. [77]

Conclusion

The nation's high rates of maternal and infant mortality sit at the epicenter of converging crises of racism, the COVID-19 pandemic, and economic inequality that undermine efforts to achieve health equity. Women who live in expansion states are twice as likely to have coverage as their peers in non-expansion states, and states that refuse to expand Medicaid are denying future parents the opportunity to access regular health care before, during, and after pregnancy.

Yet even after expansion, all states have more work to do to address alarming racial disparities in coverage rates and health outcomes. Extending postpartum coverage to one year after the end of pregnancy, facilitating greater access to community-based support providers , and using Medicaid managed care contracting to incentivize high-value maternity care are just some of the ways states can leverage Medicaid to better support women, especially women of color, in pregnancy and throughout their lives.

State and federal policymakers have an urgent responsibility to address the maternal mortality crisis by expanding Medicaid and closing the coverage gap. While Medicaid expansion alone cannot undo the harm of racism and economic hardship that weighs on young families of color, expansion builds a foundation of coverage that ensures that women and families have access to lifesaving care throughout this important stage of life.

Online Chartbook

Please visit our website to view an online chartbook with additional data and visualizations related to the report findings. You can find the chartbook at https://bit.ly/3jXaWid.

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- Chart 3: Uninsured Rate for Women of Childbearing Age (18-44) by Poverty Level, 2013-2019
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Appendix A: Uninsured Rate for Reproductive Age Women (18-44) by State and Race, 2019

State	American Indian/Alaska Native	Asian/Native Hawaiian/Pacific Islander	Black/African American	Other	White
US	**24.0**	**7.7**	**13.3**	**20.7**	**12.0**
Alabama	--	--	15.5	26.9	13.9
Alaska	29.9	--	--	--	10.2
Arizona	26.9	9.8	13.3	19.3	14.4
Arkansas	--	23.0	12.5	23.9	12.5
California	11.1	6.3	7.8	14.5	9.7
Colorado	21.8	10.0	8.6	16.6	10.0
Connecticut	--	--	6.0	18.4	5.7
Delaware	--	--	--	--	9.3
DC	--	--	--	--	--
Florida	28.9	14.9	20.4	27.7	18.4
Georgia	35.9	10.5	18.3	38.0	18.8
Hawaii	--	7.3	--	4.6	6.3
Idaho	--	--	--	22.4	16.1
Illinois	--	7.1	10.1	20.2	8.2
Indiana	--	7.5	14.4	22.4	11.2
Iowa	--	--	--	--	4.6
Kansas	--	--	17.9	32.4	12.9
Kentucky	--	--	12.4	22.8	7.9
Louisiana	--	21.2	8.3	27.3	11.8
Maine	--	--	--	--	10.2
Maryland	--	5.4	7.3	29.5	5.9
Massachusetts	--	3.1	4.9	5.6	3.3
Michigan	--	5.2	7.6	11.6	7.3
Minnesota	--	5.0	--	14.0	5.3
Mississippi	34.8	--	21.3	28.8	20.6
Missouri	--	10.6	16.3	24.0	14.8
Montana	35.0	--	--	--	8.7
Nebraska	35.8	--	--	--	9.9
Nevada	25.2	11.4	10.7	23.8	14.8
New Hampshire	--	--	31.9	--	8.5
New Jersey	--	6.2	11.0	24.9	10.1
New Mexico	22.8	--	--	20.1	9.9
New York	--	6.7	6.6	13.8	5.1
North Carolina	21.7	9.4	15.9	33.3	15.0
North Dakota	--	--	--	--	7.4
Ohio	--	8.3	11.1	14.4	8.2
Oklahoma	36.1	--	22.2	31.6	20.7
Oregon	--	--	--	13.9	8.5
Pennsylvania	--	7.3	8.4	14.6	6.9
Rhode Island	--	--	--	--	4.1
South Carolina	--	14.9	14.2	34.1	13.5
South Dakota	46.5	--	--	--	10.6
Tennessee	--	--	13.0	34.2	12.8
Texas	23.8	12.0	21.4	37.9	26.7
Utah	47.2	--	--	32.7	10.3
Vermont	89.8	--	--	--	4.3
Virginia	--	7.1	11.3	25.1	9.4
Washington	16.0	6.7	11.8	18.1	7.6
West Virginia	--	--	--	--	8.2
Wisconsin	--	--	--	24.2	6.6
Wyoming	62.1	--	--	--	17.5

-- Indicates that the estimate is suppressed due to small sample size and low reliability. See methodology section for more details.

Note: "Other" category includes those who identify as "two or more races" or "some other race."

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau American Community Survey (ACS) 2019 Public Use Microdata Sample (PUMS).

Appendix B: Uninsured Rate for Reproductive Age Women (18-44) by State and Ethnicity, 2019

State	Hispanic/Latina	Not Hispanic/Latina
US	24.3	9.8
Alabama	33.2	13.8
Alaska	--	12.8
Arizona	21.8	11.4
Arkansas	32.2	11.5
California	15.4	6.0
Colorado	21.2	7.3
Connecticut	13.8	5.6
Delaware	23.8	6.8
DC	--	2.2
Florida	25.5	16.7
Georgia	45.9	16.2
Hawaii	--	6.3
Idaho	26.9	14.6
Illinois	20.0	7.1
Indiana	25.5	10.8
Iowa	16.3	4.2
Kansas	34.8	11.3
Kentucky	27.5	7.9
Louisiana	36.6	9.7
Maine	--	11.1
Maryland	29.8	5.6
Massachusetts	4.8	3.4
Michigan	14.5	7.0
Minnesota	22.0	5.2
Mississippi	46.9	20.3
Missouri	29.8	14.5
Montana	--	10.2
Nebraska	26.6	8.5
Nevada	26.3	10.4
New Hampshire	24.6	8.8
New Jersey	25.4	6.9
New Mexico	13.8	11.4
New York	12.8	5.0
North Carolina	41.8	13.2
North Dakota	--	8.7
Ohio	19.6	8.3
Oklahoma	39.5	20.7
Oregon	19.2	7.0
Pennsylvania	14.0	6.9
Rhode Island	--	4.5
South Carolina	38.1	13.1
South Dakota	--	15.4
Tennessee	49.2	11.2
Texas	39.0	16.8
Utah	27.6	9.5
Vermont	--	5.6
Virginia	31.6	8.1
Washington	23.5	6.4
West Virginia	--	8.3
Wisconsin	29.8	5.6
Wyoming	29.5	18.0

-- Indicates that the estimate is suppressed due to small sample size and low reliability. See methodology section for more details.

Note: Hispanic/Latino refers to a person's ethnicity, therefore Hispanic individuals may be of any race.

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau American Community Survey (ACS) 2019 Public Use Microdata Sample (PUMS).

Appendix C: Uninsured Rate for Reproductive Age Women (18-44) by State, 2013-2019

State	2013	2019	Percentage Point Change
US	**21**	**12.8**	**-8.2***
Alabama	23	14.8	-8.3*
Alaska	25.5	13.9	-11.6*
Arizona	24.2	15.3	-8.9*
Arkansas	26.3	13.4	-12.9*
California	23.4	10.1	-13.3*
Colorado	18.6	10.7	-7.9*
Connecticut	12.1	7.3	-4.8*
Delaware	12.7	8.8	-3.9*
DC	5.5	2.4	-3.1*
Florida	29	19.4	-9.6*
Georgia	27.5	19.3	-8.2*
Hawaii	9.8	6.2	-3.5*
Idaho	24.4	16.5	-7.9*
Illinois	17.2	9.6	-7.5*
Indiana	21	12.1	-8.9*
Iowa	12.7	5.2	-7.5*
Kansas	20.2	14.7	-5.4*
Kentucky	24	8.8	-15.3*
Louisiana	25.9	11.2	-14.7*
Maine	15.8	11.1	-4.8*
Maryland	13.9	8.4	-5.5*
Massachusetts	4.6	3.6	-1.0*
Michigan	16.4	7.5	-8.9*
Minnesota	10.8	6.4	-4.5*
Mississippi	26.2	21.2	-5.0*
Missouri	19.6	15.3	-4.3*
Montana	23.7	10.6	-13.2*
Nebraska	16.8	10.9	-5.8*
Nevada	29	15.8	-13.2*
New Hampshire	16.5	9.7	-6.8*
New Jersey	19.7	11.3	-8.3*
New Mexico	29.8	12.7	-17.0*
New York	14.2	6.6	-7.6*
North Carolina	24.1	16.4	-7.7*
North Dakota	14.4	9.1	-5.3*
Ohio	15.1	8.9	-6.2*
Oklahoma	27.2	23.1	-4.1*
Oregon	20.8	8.9	-11.9*
Pennsylvania	13.9	7.6	-6.3*
Rhode Island	15.8	6.2	-9.6*
South Carolina	23.9	14.7	-9.2*
South Dakota	19.8	15.9	-3.9*
Tennessee	18.9	13.6	-5.3*
Texas	32.2	26.2	-6.0*
Utah	18.3	12.3	-6.0*
Vermont	8	5.5	-2.5*
Virginia	17.4	10.7	-6.7*
Washington	21.4	9	-12.4*
West Virginia	24.6	8.4	-16.2*
Wisconsin	11.8	7.7	-4.0*
Wyoming	19.4	19.5	0.1

* Indicates that change is significant at the 90% confidence level relative to the prior year indicated.

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau American Community Survey (ACS) 2013-2019 Public Use Microdata Sample (PUMS).

Appendix D: Number of Uninsured Reproductive Age Women (18-44) by State, 2013-2019

State	2013	2019	Number Change
US	**11,950,800**	**7,462,700**	**-4,488,100***
Alabama	201,600	128,200	-73,400*
Alaska	33,800	18,500	-15,300*
Arizona	281,200	192,700	-88,500*
Arkansas	136,200	70,000	-66,200*
California	1,692,000	738,700	-953,300*
Colorado	180,700	114,700	-66,000*
Connecticut	74,300	43,900	-30,400*
Delaware	20,800	14,400	-6,400*
DC	9,100	4,300	-4,800*
Florida	955,700	685,700	-270,000*
Georgia	523,700	381,100	-142,600*
Hawaii	23,800	14,900	-8,900*
Idaho	67,600	50,700	-16,900*
Illinois	404,900	218,200	-186,700*
Indiana	244,600	142,500	-102,100*
Iowa	67,200	27,800	-39,400*
Kansas	101,100	74,900	-26,200*
Kentucky	185,200	66,900	-118,300*
Louisiana	222,600	94,700	-127,900*
Maine	33,500	23,800	-9,700*
Maryland	151,000	90,400	-60,600*
Massachusetts	57,000	46,100	-10,900*
Michigan	277,900	127,900	-150,000*
Minnesota	103,000	62,900	-40,100*
Mississippi	143,300	112,700	-30,600*
Missouri	207,200	161,900	-45,300*
Montana	40,100	18,700	-21,400*
Nebraska	55,000	37,200	-17,800*
Nevada	146,100	85,900	-60,200*
New Hampshire	36,500	21,600	-14,900*
New Jersey	304,900	171,300	-133,600*
New Mexico	106,800	45,800	-61,000*
New York	524,300	236,000	-288,300*
North Carolina	432,800	307,300	-125,500*
North Dakota	18,600	12,600	-6,000*
Ohio	299,500	177,400	-122,100*
Oklahoma	188,800	163,400	-25,400*
Oregon	145,600	67,600	-78,000*
Pennsylvania	303,900	164,800	-139,100*
Rhode Island	30,100	11,700	-18,400*
South Carolina	204,800	131,900	-72,900*
South Dakota	28,200	23,100	-5,100
Tennessee	220,900	165,200	-55,700*
Texas	1,608,000	1,421,600	-186,400*
Utah	103,200	77,400	-25,800*
Vermont	8,200	5,700	-2,500
Virginia	265,300	164,000	-101,300*
Washington	269,600	124,900	-144,700*
West Virginia	75,300	24,000	-51,300*
Wisconsin	115,300	76,200	-39,100*
Wyoming	19,600	18,900	-700

Estimates rounded to nearest 100.

* Indicates that change is significant at the 90% confidence level relative to the prior year indicated.

Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau American Community Survey (ACS) 2013-2019 Public Use Microdata Sample (PUMS).

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