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FACT SHEET

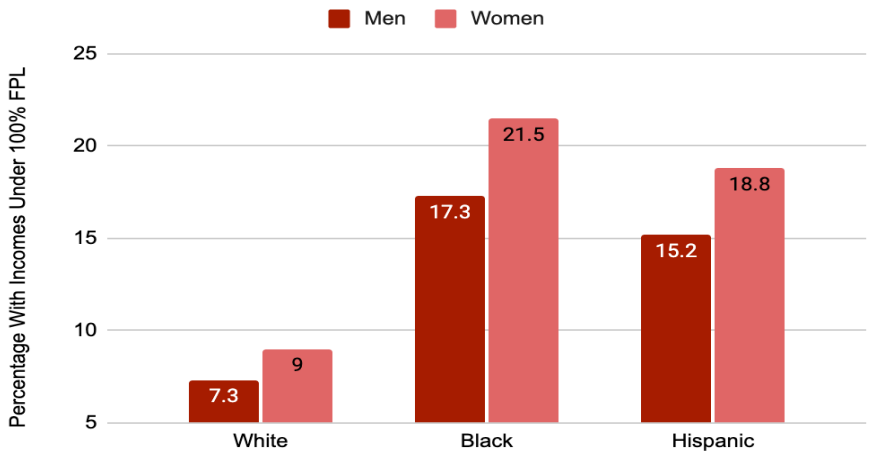
Closing the Coverage Gap Could Improve Coverage, Economic Security, and Health Outcomes for Over 650,000 Black Women

By Amanda Novello

Congress must act to close the Medicaid coverage gap. Because 12 states have denied their citizens the Affordable Care Act's Medicaid eligibility expansion, 2.2 million non-elderly adults are uninsured due to this so-called "coverage gap," 60 percent of whom are people of color, and 800,000 of whom are reproductive-aged women.[1] This fact sheet builds on these analyses to examine who would be eligible for Medicaid coverage if Congress addressed the coverage gap. This includes both women who are uninsured as well as women who may be able to access better and more affordable coverage due to their new eligibility.

Black women are more likely to be in the coverage gap income group (see Figure 1) due to the compounding impacts of sexism, racism, and their impacts on labor market outcomes such as occupational segregation, unequal and poverty-level pay, and unequal wealth. Taking legislative action to close the coverage gap would mean more than 650,000 Black women would have access to quality health insurance, largely in southern states.[2]

Figure 1: Share of Population with Incomes Below 100% Federal Poverty Line, by Race/Ethnicity and Sex



Source: 2020 data from CPS ASEC

If Congress Takes Action on the Coverage Gap, More than 650,000 Black Women Could Become Eligible for Health Coverage

The 12 states who have refused to expand Medicaid have left millions in limbo – people who make too much to qualify under state Medicaid's rules, but make too little to access the ACA's affordable marketplace plans. This group of income-eligible people includes 650,000 Black women, illustrating the racial and gender equity gap that the Medicaid coverage gap perpetuates.

Table 1: Current Medicaid Income Eligibility and # of Black Women in the Coverage Gap

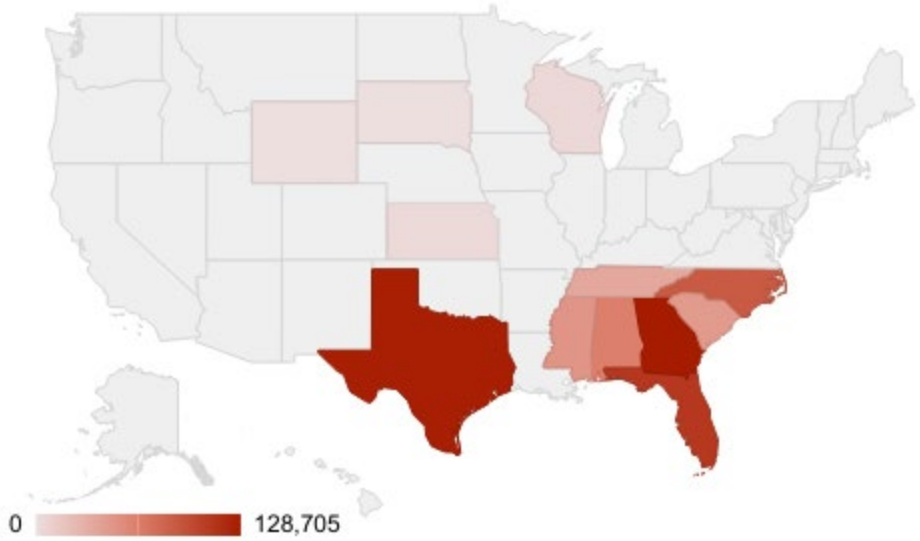
	Income Eligibility (% FPL)			*Income Eligibility (in $, based on % FPL and family size)*			
	Single Adults	**2-Adult Households**	**Households with Children**	**3-Person Households w/ Child under age 18**	**4-Person Household w/ Children under age 18**	**5-Person Household w/ Children under age 18**	**# Black Women In Coverage Gap**
Alabama	0	0	13%	$2,994	$3,608	$4,221	**64,005**
Florida	0	0	27%	$6,218	$7,493	$8,767	**110,036**
Georgia	0	0	31%	$7,139	$8,603	$10,066	**128,705**
Kansas	0	0	33%	$7,600	$9,158	$10,715	**3,815**
Mississippi	0	0	21%	$4,836	$5,828	$6,819	**48,830**
North Carolina	0	0	40%	$9,212	$11,100	$12,988	**87,780**
South Carolina	0	0	95%	$21,879	$26,363	$30,847	**45,334**
South Dakota	0	0	52%	$11,976	$14,430	$16,884	**INS**
Tennessee	0	0	95%	$21,879	$26,363	$30,847	**36,298**
Texas	0	0	14%	$3,224	$3,885	$4,546	**126,410**
Wisconsin	100%	100%	95%	$21,879	$26,363	$30,847	**294**
Wyoming	0	0	51%	$11,745	$14,153	$16,560	**INS**
						Total:	**652,015**

Source: Current eligibility rates from Medicaid.gov and FPL caculator

Note: Sample sizes are too small to include data on Black women in South Dakota or Wyoming. Weighted estimates for these states are included in the national total, but are not sufficient to provide a state-level estimate.

The graph below indicates the number of non-elderly Black women who fall between the current maximum income eligibility level, and 100% FPL.

Figure 3: Black Women in the Coverage Gap by State of Residence



Source: Data from IPUMS USA 2019 and authors' calculations, due to irregularities in the 2020 data sample.
Notes: Data include those who identify as Black women, who may also identify as Hispanic/Latina in ethnicity, are non-elderly, and who did not have insurance through Medicaid. Analysis is based on current income eligibility levels as shown in Table 1. Analysis includes women in households of up to 5 people, therefore is a conservative estimate due to the exclusion of women with larger family sizes.
This analysis uses federal poverty levels and respective HHS guidelines as proxy for Medicaid eligibility, which is based on Modified Adjusted Gross Income, or MAGI, see more here.

Why This Matters: Four Ways that Medicaid Supports Women's Health and Economic Security

1. **Medicaid expansion drastically decreased the uninsurance rate.** Medicaid expansion was a turning point in access to health care for people with low incomes in the United States. In states that expanded Medicaid, the share of people with incomes below 200% of the Federal Poverty Line (FPL) who were uninsured was cut in half, from 35% in 2013 to 17% in 2019.[3] Comparatively, uninsurance rates dropped in non-expansion states from 43% in 2013 to only 34% in 2019 — in other words, more than one in three low-income people in non-expansion states did not have health insurance coverage in 2019.

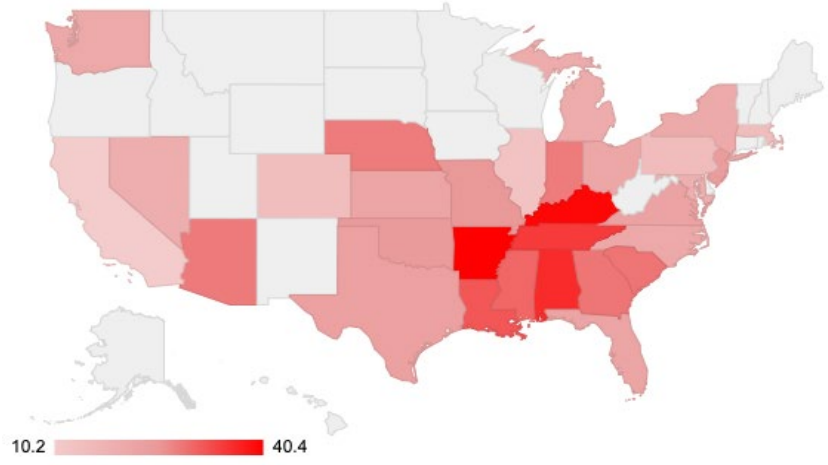
In 2020, Medicaid covered 16% of nonelderly adult women in the United States, and roughly two-thirds (64%) of adult women with Medicaid coverage are in their reproductive years (aged 19 to 49).[4] Medicaid covers nearly half of all women who fall below the FPL.[5] Since Black and Latina women are more likely to live in poverty due to systemic and structural inequities (see Figure 1), they are more likely to be eligible and receive coverage through Medicaid when it is

available. Medicaid provides health insurance for one in five (22%) of Latinas, one in four (25%) of Black women, and 40 percent of single mothers.[6]

2. **Medicaid reduces the financial burden of health care that disproportionately harms low-income women and families and reduces medical debt.** Women are much more likely to forgo care due to cost and are more likely to have difficulty paying medical bills than men.[7] However, with access to Medicaid, women are much less likely to forgo care or have trouble paying than women with private insurance or no insurance.[8] Various studies have shown that Medicaid expansion improves financial security among low-income families, including reductions in debt delinquency[9] and reliance on predatory loans,[10] and improved credit scores.[11] Medical debt has accrued the most in low-income communities in the South[12] — the same communities that lack access to Medicaid because states have not implemented Medicaid expansion. Expanding Medicaid in those states would have great potential for economic and health justice for these communities.

3. **Medicaid saves the lives of moms and babies.** Medicaid is the largest payer for pregnancy-related services in the United States - the program covered 42% of all U.S. births in 2019,[13] in addition to prenatal care. States that expand Medicaid must cover a broad range of preventive services for pregnant women without any cost-sharing, including prenatal screenings, folic acid supplements, and breastfeeding support. Medicaid expansion is associated with an increase in prenatal care,[14] and has contributed to lower maternal mortality rates when compared with states that have not expanded Medicaid.[15] Medicaid expansion has also been linked to declines in infant mortality, with the steepest declines for Black babies.[16]

Figure 2: Maternal Mortality Rate by State, 2018-2020



Source: Data from the CDC. Deaths per 100,000 by state, from 2018-2022.

Currently, all the non-expansion states have maternal mortality rates that are higher than the national average. These same states have larger populations of Black women, and their lack of access to critical services that should be provided through Medicaid continuously contributes to the crisis of Black maternal mortality.[17]

4. **Medicaid improves access to and use of preventive health care and improves health outcomes.** In 2019, 57% of women ages 30+ who were covered by Medicaid reported having a mammogram in the past year, compared with only 34% of uninsured women. Research shows that women with insurance coverage are more likely to report having had a mammogram in the past two years. This lack of coverage contributes to inequities in which women in states that have not expanded Medicaid have higher breast cancer and cervical cancer mortality rates than in those that have.[18]

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[1] CBPP's analysis includes uninsured adults in the coverage gap, while the analysis in this paper includes those in the coverage gap who are not enrolled in Medicaid, but who may have other insurance. Therefore we are not drawing direct comparison between the two findings, rather, providing a sense of scale and character of the coverage gap population overall.
[2] For analysis, see Table 1 and Figure 3.
[3] Data are specific to those with incomes below 200% FPL. See: Rubin, I., Cross-Call, J., & Lukens, G. (2021, June). *Medicaid Expansion: Frequently Asked Questions.* Retrieved 12 July 2022, from CBPP website: https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions
[4] Gomez, I., Ranji, U., Salaganicoff, A., & Frederiksen, B. (2022, February). *Medicaid Coverage for Women.* Retrieved 12 July 2022, from KFF website: https://www.kff.org/womens-health-policy/issue-brief/medicaid-coverage-for-women/
[5] See Figure 3, Ibid.
[6] Ibid.
[7] See Figure 4: Ranji, R., Rosenzweig, C., & Salganicoff, A. (2018, March). *Women's Coverage, Access, and Affordability: Key Findings from the 2017 Kaiser Women's Health Survey.* Retrieved 12 July 2022, from KFF website: https://www.kff.org/womens-health-policy/issue-brief/womens-coverage-access-and-affordability-key-findings-from-the-2017-kaiser-womens-health-survey/
[8] See Figure 5, Ibid.
[9] Brevoort, K., Grodzicki, D., & Hackmann, M. B. (2017). *Medicaid and financial health* (No. w24002). National Bureau of Economic Research.
[10] Allen, H., Swanson, A., Wang, J., & Gross, T. (2017). *Early Medicaid expansion associated with reduced payday borrowing in California*. Health Affairs, 36(10), 1769-1776.
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[12] Bennet, N., Eggleston, J., Mykyta, L., & Sullivan, B. (2021, April). *19% of U.S. Households Could Not Afford to Pay for Medical Care Right Away.* Retrieved 12 July, 2022, from CDC website: https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html
[13] National Vital Statistics Reports. (2021, March). *Births: Final Data for 2019.* Volume 70, No. 2. Retrieved 12 July, 2022 from CDC: https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-02-508.pdf
[14] Harvey, S. M., Oakley, L. P., Gibbs, S. E., Mahakalanda, S., Luck, J., & Yoon, J. (2021). *Impact of Medicaid expansion in Oregon on access to prenatal care.* Preventive Medicine, 143, 106360.
[15] Clark, M., Bargeron, E., & Corcoran, A. (2021, September). *Medicaid Expansion Narrows Maternal Health Coverage Gaps, But Racial Disparities Persist.* Retrieved 12 July, 2022, from Georgetown CCF website: https://ccf.georgetown.edu/2021/09/13/medicaid-expansion-narrows-maternal-health-coverage-gaps-but-racial-disparities-persist/#_edn17
[16] Ibid.
[17] Hoyert, D. L. (2020). *Maternal Mortality Rates in the United States, 2020.* Retrieved 12 July 2022, from CDC website: https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm
[18] Authors' analysis of data from the Kaiser Family Foundation: https://www.kff.org/statedata/custom/

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