HEALTH CARE PAYMENTS AND WORKFORCE

The indicators studied in this report are shaped by a broad range of factors, many of which are determined by policies made at the state level. State-level policies help establish the context for the operation of the private health care marketplace, the role of public payers and providers, and ultimately women's experiences in the health care system. The characteristics of the providers serving communities, the availability of public funding sources that serve low-income populations, and policies that can enhance or limit access to services all affect the accessibility and availability of care for women of color.

This chapter examines health care workforce measures: health professional shortage areas, mental health professional shortage areas, and the physician diversity ratio, which is a measure of how well the racial and ethnic composition of the physician population reflects the diversity of the state's population. A patient's recognition of symptoms, ability to communicate those symptoms, and adherence to treatment plans may be influenced by socio-cultural factors.[73] A health care workforce that is representative of the population it serves is an important factor in assuring more accessible, quality health care for minority populations.[74]

This report also examines three measures of Medicaid policy, an area in which states have a major role. Under broad federal guidelines, each state operates its own program, determining eligibility, payment, and benefit levels. As a result, there is tremendous variation among states in terms of eligibility, scope of benefits, access to providers, and administrative requirements. Women comprise the vast majority of the adult population on Medicaid since they are more likely to qualify for the program's income and categorical requirements. On average, women have lower incomes and are generally more likely to have responsibility for raising children, compared to men. The Medicaid measures examined in this report include the Medicaid-to-Medicare fee index, income eligibility level for working parents, and the income eligibility level for pregnant women.

States also play a large role in establishing policies that affect access to reproductive health services. Family planning and abortion services encompass some of the medical services most commonly used by women. Resources states dedicate to family planning programs and policies that affect abortion access can directly affect the range of reproductive care that is available and accessible to women. In this report, we looked at three such measures—whether there is a mandatory waiting period for an abortion, whether there is Medicaid funding for an abortion, and the percentage of women who live in counties with no abortion provider.

The tables that follow present indicators that describe state policies that affect health care availability, financing, and infrastructure. The indicators included in this chapter are:

1. Physician Diversity Ratio
2. Primary Care Health Professional Shortage Area
3. Mental Health Professional Shortage Area
4. Medicaid-to-Medicare Fee Index
5. Medicaid Income Eligibility for Working Parents
6. Medicaid/SCHIP Income Eligibility for Pregnant Women
7. Family Planning Funding
8. Abortion Access Policies

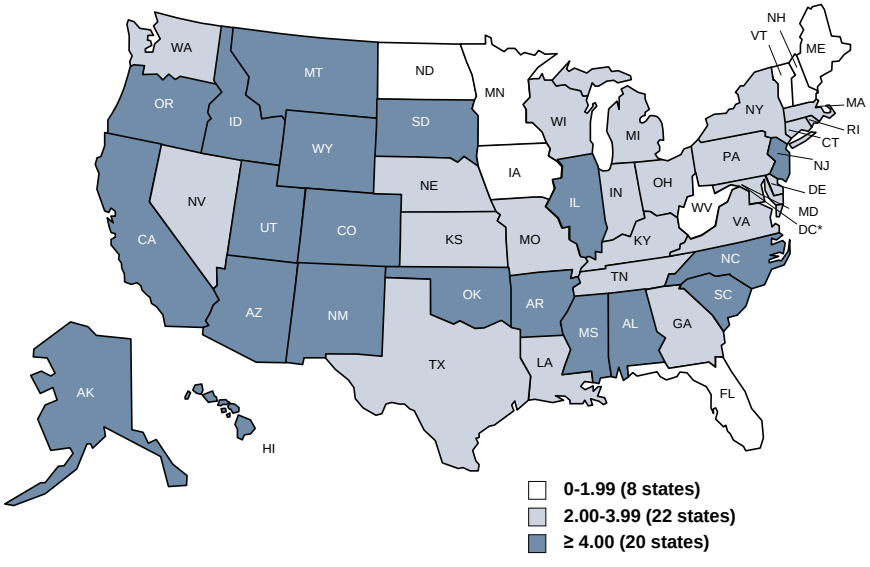
PHYSICIAN DIVERSITY RATIO

Having a health care workforce that reflects the racial and ethnic composition of the population it serves plays an important role in creating a delivery system that is culturally competent and more responsive to the health and social needs of the community.[75] Although the number of physicians of color has been growing in recent years, African Americans, Latinos, and American Indian and Alaska Natives are still underrepresented in the physician workforce. Analysts have also emphasized the importance of increasing the diversity of the broader health care workforce, including nurses, dentists, mental health providers, and other health professionals. As the nation's population becomes more diverse, developing the pipeline of a more diverse health workforce for the future could become even more important.

The physician diversity ratio was created to measure the degree to which a state's physician workforce is representative of the racial and ethnic composition of the state's population.[76] Using the 2000 U.S. Census and the AMA Physician Masterfile, this indicator represents the factor by which the physician workforce would need to be changed so that the ratio of minority physicians to the minority population would match the ratio of White physicians to the White population living in the state.

- There are significant state variations in the racial and ethnic composition of the physician workforce and how closely it matches the state's own demographics. The physician diversity ratio ranged from 0.91 in West Virginia, where the physician workforce was more diverse than the population, to 11.53 in Illinois, where the proportion of physicians who were White far exceeded the proportion of residents. In order to have a physician workforce that matches its population, Illinois would need to increase its current number of underrepresented minority physicians 11 times.
- States with very large White populations (West Virginia, Maine, and New Hampshire) had a diversity ratio near 1.00, meaning their physician composition closely reflected their demographic distribution.
- States with the largest population of minorities tended to have physician workforces that were the least reflective of their demographic composition. Mostly clustered in the West (Alaska, Hawaii, California, and Oregon) and South (Alabama, Mississippi, Arkansas, Oklahoma, South Carolina, and North Carolina), twenty states would need to increase the number of underrepresented minority physicians four-fold or more in order to reach population parity with White physicians.

FIGURE 4.1. Physician Diversity Ratio, by State



Note: The physician diversity ratio is the factor by which underrepresented minority physicians must increase to reach population parity with white physicians. *The physician diversity ratio for District of Columbia was not included.
Source: Trivedi AN et al. Creating a state minority health policy report card. *Health Affairs,* 24(2). 2005.

TABLE 4.1. Physician Diversity Ratio, by State

State	Physician Diversity Ratio
Alabama	4.27
Alaska	6.93
Arizona	5.70
Arkansas	4.29
California	5.60
Colorado	6.49
Connecticut	3.47
Delaware	2.47
Florida	1.34
Georgia	2.96
Hawaii	6.51
Idaho	6.38
Illinois	11.53
Indiana	2.25
Iowa	1.61
Kansas	2.34
Kentucky	2.30
Louisiana	3.69
Maine	0.94
Maryland	2.64
Massachusetts	2.34
Michigan	2.04
Minnesota	1.91
Mississippi	6.71
Missouri	2.36
Montana	4.00
Nebraska	2.80
Nevada	3.93
New Hampshire	1.09
New Jersey	5.63
New Mexico	4.66
New York	3.28
North Carolina	4.56
North Dakota	1.44
Ohio	2.01
Oklahoma	4.49
Oregon	4.69
Pennsylvania	2.54
Rhode Island	2.70
South Carolina	6.87
South Dakota	6.43
Tennessee	2.73
Texas	3.15
Utah	6.47
Vermont	1.35
Virginia	3.21
Washington	3.94
West Virginia	0.91
Wisconsin	3.09
Wyoming	6.14

Note: The physician diversity ratio for the District of Columbia was not calculated.
Source: Trivedi AN et al. Creating a state minority health policy report card. *Health Affairs*, 24(2).

— — — Best state in column

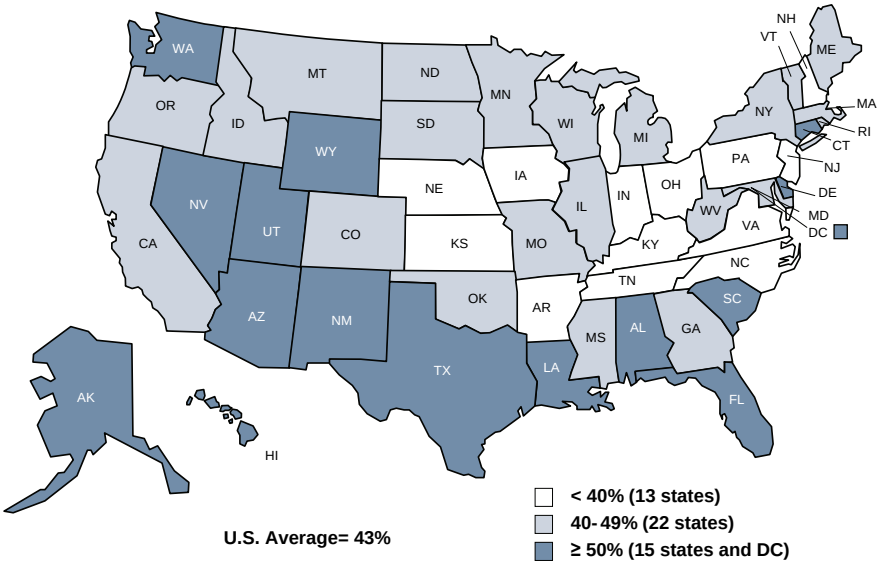
——— Worst state in column

PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE AREA

Primary care is an essential component of the health care delivery system, particularly in medically underserved communities. Primary care providers can address a wide range of health care needs and guide patients through the health care system, which is particularly critical for women due to more frequent interactions with the health care system, roles in their family's health as mothers and caregivers, and unique reproductive health needs. Access to primary care services, especially for the poor, has resulted in improved preventive care such as higher rates of screenings and immunizations.[77] With poorer access to primary care health providers, patients may resort to emergency departments, which can be more costly. Evidence suggests that a shortage of primary care workforce and services contributes to poorer health outcomes, wider health disparities and an increase in health care costs.[78] Using the Health Resources and Services Administration's (HRSA) 2004 Area Resource File, this indicator measures the proportion of women living in a primary care health professional shortage area, based on the criteria developed by HRSA's Bureau of Primary Health Care.

- Almost half of women (43%) nationwide lived in an area where there is a shortage of primary care providers. The percentages ranged from a low of 22% of women in Virginia to 61% in New Mexico.
- In 15 states and the District of Columbia, the percentage of women who lived in areas with a shortage of primary care providers was 50% or greater.
- Western and Southern states tended to have larger primary care workforce shortages. These states had a disproportionate number of isolated and low-income rural communities, where health care providers are in short supply.

FIGURE 4.2. Percent of Women Living in a Primary Care Health Professional Shortage Area, by State



Source: Area Resource File, 2004.

TABLE 4.2. Primary Care Health Professional Shortage Area, by State

State	Percent of Women Living in a Primary Care Health Professional Shortage Area
All States	**43%**
Alabama	55%
Alaska	50%
Arizona	51%
Arkansas	34%
California	49%
Colorado	42%
Connecticut	50%
Delaware	50%
District of Columbia	50%
Florida	51%
Georgia	41%
Hawaii	50%
Idaho	40%
Illinois	48%
Indiana	34%
Iowa	34%
Kansas	36%
Kentucky	36%
Louisiana	51%
Maine	47%
Maryland	40%
Massachusetts	45%
Michigan	43%
Minnesota	41%
Mississippi	46%
Missouri	49%
Montana	47%
Nebraska	31%
Nevada	52%
New Hampshire	28%
New Jersey	29%
New Mexico	61%
New York	40%
North Carolina	28%
North Dakota	40%
Ohio	38%
Oklahoma	47%
Oregon	43%
Pennsylvania	37%
Rhode Island	40%
South Carolina	51%
South Dakota	47%
Tennessee	38%
Texas	50%
Utah	52%
Vermont	41%
Virginia	22%
Washington	51%
West Virginia	44%
Wisconsin	45%
Wyoming	54%

Source: Area Resource File, 2004.

— — — Best state in column

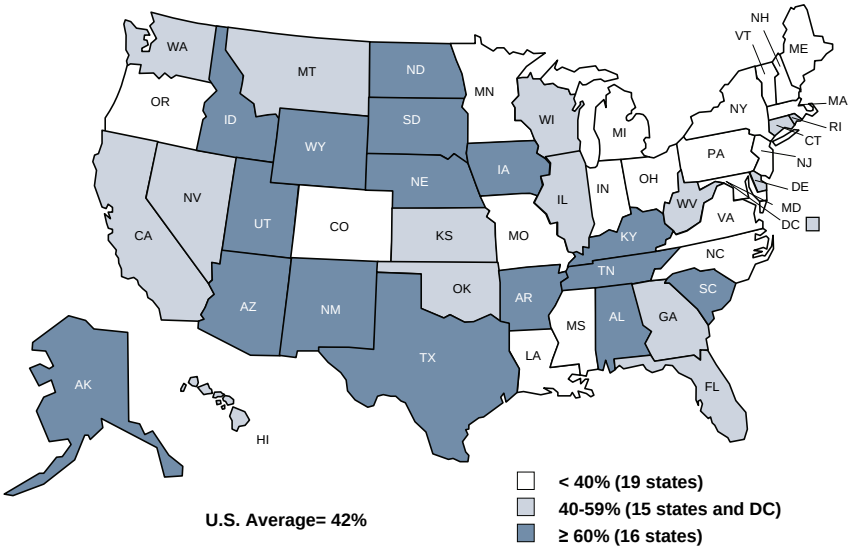
——— Worst state in column

MENTAL HEALTH PROFESSIONAL SHORTAGE AREA

Mental health is essential to overall health and well-being. Women have higher rates of depression, anxiety, and eating disorders than men. Geographic variations in the availability of mental health services contribute to disparities in access to mental health services. Limitations in private and public sources of insurance to cover mental health services also contribute to these disparities. Access to mental health providers and services is particularly critical in low-income areas where people with mental health needs have fewer financial resources to seek care outside their communities. Using the Health Resources and Services Administration's (HRSA) 2004 Area Resource File, this indicator measures the proportion of women living in a mental health professional shortage area, based on criteria developed by HRSA's Bureau of Primary Health Care.

- More than four in ten women (42%) nationwide lived in an area with a shortage of mental health providers. The percentages ranged from a low of 4% of women in Mississippi to all of the women in Idaho and Wyoming.
- As with primary care professional shortages, Western and Southern regions tended to have a greater shortage of mental health workforce likely due to the higher concentration of rural communities.
- Women in the Northeastern states lived in areas with higher numbers of mental health care providers, but even in some of these states, one-third of women lived in mental health professional shortage areas.

FIGURE 4.3. Percent of Women Living in a Mental Health Professional Shortage Area, by State



Source: Area Resource File, 2004.

TABLE 4.3. Mental Health Professional Shortage Area, by State

State	Percent of Women Living in a Mental Health Professional Shortage Area
All States	**42%**
Alabama	78%
Alaska	68%
Arizona	60%
Arkansas	68%
California	50%
Colorado	37%
Connecticut	45%
Delaware	40%
District of Columbia	50%
Florida	47%
Georgia	46%
Hawaii	50%
Idaho	100%
Illinois	45%
Indiana	22%
Iowa	62%
Kansas	43%
Kentucky	61%
Louisiana	18%
Maine	35%
Maryland	10%
Massachusetts	35%
Michigan	32%
Minnesota	39%
Mississippi	4%
Missouri	37%
Montana	58%
Nebraska	74%
Nevada	44%
New Hampshire	12%
New Jersey	17%
New Mexico	73%
New York	36%
North Carolina	16%
North Dakota	62%
Ohio	18%
Oklahoma	59%
Oregon	36%
Pennsylvania	28%
Rhode Island	43%
South Carolina	61%
South Dakota	69%
Tennessee	60%
Texas	60%
Utah	65%
Vermont	31%
Virginia	22%
Washington	50%
West Virginia	40%
Wisconsin	53%
Wyoming	100%

Source: Area Resource File, 2004.

— — — Best state in column

——— Worst state in column

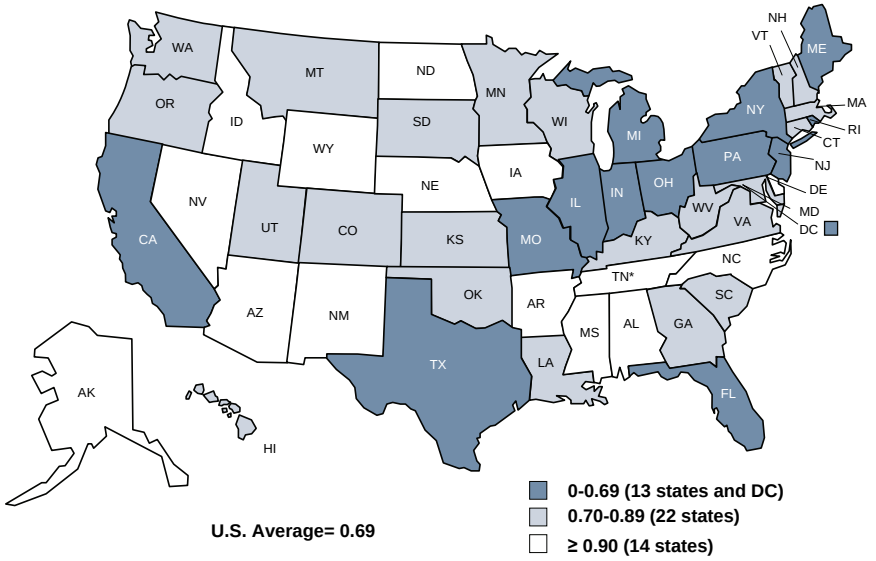
MEDICAID-TO-MEDICARE FEE INDEX

Health care providers' willingness to accept public coverage like Medicaid is affected by the level of payment that they receive from the program. Medicaid historically has had low rates of provider participation, due in large part to lower reimbursement levels relative to Medicare and private insurers. These low rates have prompted many providers to restrict the number of Medicaid patients they see or to drop Medicaid patients altogether, and has made access to care, particularly specialty care, a problem for Medicaid beneficiaries whose health and social needs are often quite complex.

The Medicaid-to-Medicare fee index measures each state's Medicaid fee-for-service physician fees relative to Medicare fees in the state. The Medicaid-to-Medicare fee index is a weighted sum of the ratios of each state's Medicaid fee for a given service to the Medicare fee, using expenditure weights from the year 2000.[79] This index provides a measure of states' reimbursement levels in the fee-for-service marketplace, and thus can serve as a marker for providers' willingness to participate in Medicaid.

- In general, Medicaid physician fees for all services lagged behind Medicare fees by nearly a third; nationally overall, Medicaid fees averaged 69% of Medicare fees. Medicaid fees for primary care averaged slightly lower than for overall services, at 62% of the Medicare rate. Conversely, Medicaid fees for obstetric services were higher than Medicaid fees for other services, but still lower than Medicare, averaging 84% of Medicare fees.
- Since states set their own Medicaid physician fee levels, there is considerable variation across states. Average Medicaid physician fees for services overall ranged from a low of 35% of Medicare fees in New Jersey to a high of 137% in Alaska. For primary care, the range was 34% of Medicare fees in New Jersey and Rhode Island to 138% in Alaska. For obstetric care, fees ranged from 31% in New Jersey to 160% in South Carolina.
- The Northeastern region had lower Medicaid physician fees relative to Medicare physician fees than other regions of the country.
- In most states, physician fees were lower in Medicaid compared to Medicare for all services as well as primary and obstetric care. Medicaid physician fees relative to Medicare were lower in all but four states for overall services and lower in every state but three for primary care. By comparison, Medicaid fees for obstetric services were at least as high as Medicare fees in many more states. Yet, in the majority of states, Medicaid fees for obstetric services remained below those of Medicare.

FIGURE 4.4. Medicaid-to-Medicare Fee Index, by State



Note: This map is the overall Medicaid-to-Medicare fee index, which includes primary care, obstetric care, and other services.
*Tennessee does not have a fee-for-service (FFS) component in their Medicaid programs.
Source: Zuckerman S, McFeeters J, Cunningham P et al. Exhibit 2, Medicaid fee indexes and Medicaid-to-Medicare Fee Indexes, 2003. *Health Affairs*. 2004.

TABLE 4.4. Medicaid-to-Medicare Fee Index, by State

State	Overall	Primary Care	Obstetric Care
United States	**0.69**	**0.62**	**0.84**
Alabama	0.90	0.82	1.19
Alaska	1.37	1.38	1.38
Arizona	1.06	1.01	1.17
Arkansas	0.95	0.96	0.78
California	0.59	0.51	0.65
Colorado	0.74	0.68	0.86
Connecticut	0.83	0.74	1.16
Delaware	1.01	1.00	1.02
District of Columbia	0.52	0.35	0.94
Florida	0.65	0.60	0.82
Georgia	0.81	0.68	1.00
Hawaii	0.74	0.71	0.79
Idaho	0.92	0.89	0.99
Illinois	0.63	0.54	0.84
Indiana	0.68	0.60	0.77
Iowa	0.97	0.94	1.01
Kansas	0.75	0.63	0.92
Kentucky	0.76	0.63	1.11
Louisiana	0.73	0.70	0.89
Maine	0.65	0.54	0.84
Maryland	0.80	0.76	1.03
Massachusetts	0.80	0.72	0.98
Michigan	0.62	0.63	0.60
Minnesota	0.79	0.64	0.82
Mississippi	0.91	0.90	0.85
Missouri	0.56	0.50	0.71
Montana	0.86	0.75	0.97
Nebraska	0.95	0.78	0.94
Nevada	0.98	0.71	1.30
New Hampshire	0.72	0.67	0.96
New Jersey	0.35	0.34	0.31
New Mexico	0.95	0.93	0.95
New York	0.45	0.40	0.65
North Carolina	0.97	0.96	1.01
North Dakota	0.91	0.90	0.94
Ohio	0.68	0.66	0.79
Oklahoma	0.72	0.67	0.81
Oregon	0.86	0.75	1.17
Pennsylvania	0.52	0.43	0.90
Rhode Island	0.42	0.34	0.50
South Carolina	0.89	0.75	1.60
South Dakota	0.83	0.68	0.88
Tennessee*	N/A	N/A	N/A
Texas	0.69	0.62	0.82
Utah	0.73	0.66	0.86
Vermont	0.83	0.64	1.14
Virginia	0.77	0.73	0.84
Washington	0.87	0.79	1.22
West Virginia	0.88	0.82	1.19
Wisconsin	0.87	0.73	1.01
Wyoming	1.03	0.96	1.07

Note: The 'Overall' Medicaid-to-Medicare fee index includes primary care, obstetric care, and other services. *Tennessee does not have a fee-for-service (FFS) component in their Medicaid programs.

Source: S. Zuckerman, J. McFeeters, P. Cunningham, and L. Nichols, "Changes In Medicaid Physician Fees, 1998–2003: Implications For Physician Participation," Health Affairs, June 2004, W4-374-W4-384.

— — — Best state in column
———— Worst state in column

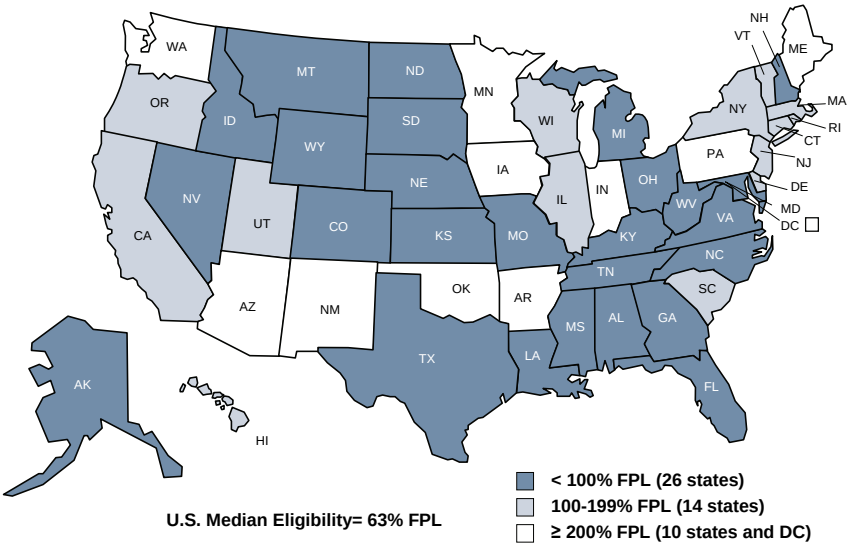
MEDICAID INCOME ELIGIBILITY FOR WORKING PARENTS

Under federal guidelines, states determine Medicaid income eligibility levels for the various populations the program serves according to minimum thresholds established by the federal government. For working parents, the threshold is very low—states need to cover only working parents with incomes below the welfare levels that were in effect in July 1996 (when the formal welfare link with Medicaid was severed and the program was fundamentally changed by federal law).

States can expand their income eligibility thresholds beyond these low levels to extend coverage to more low-income people, and many do. There are several strategies states can employ to do this; for example, they can simply raise the qualifying income thresholds or they can disregard a portion of employed parents' earnings when determining eligibility. While several states have expanded health coverage for parents through a variety of measures, Medicaid coverage for parents in most states is still quite restrictive compared to coverage for children.[80]

- There were large state variations in Medicaid income eligibility levels for working parents, ranging from 20% of the federal poverty level (FPL) in Louisiana (less than $4,000/yr for a family of three in 2008) to 409% FPL in New Mexico.
- About half of the states and the District of Columbia (24 states and DC) covered working parents with incomes at or above the poverty line ($17,600 for a family of three). Many states in the South and Central Plains regions still had eligibility thresholds that were below the federal poverty guidelines.

FIGURE 4.5. Medicaid Income Eligibility for Working Parents as a Percent of Federal Poverty Level, by State



Note: Data as of January 2008. The Federal Poverty Level (FPL) for a family of three in 2008 was $17,600 per year.
Source: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

TABLE 4.5. Medicaid Income Eligibility for Working Parents, by State

State	Medicaid Income Eligibility for Working Parents as a Percent of Federal Poverty Level
United States	**63%**
Alabama	26%
Alaska	81%
Arizona	200%
Arkansas	200%
California	106%
Colorado	66%
Connecticut	191%
Delaware	106%
District of Columbia	207%
Florida	56%
Georgia	53%
Hawaii	100%
Idaho	42%
Illinois	191%
Indiana	200%
Iowa	250%
Kansas	34%
Kentucky	64%
Louisiana	20%
Maine	206%
Maryland	37%
Massachusetts	133%
Michigan	61%
Minnesota	275%
Mississippi	32%
Missouri	39%
Montana	60%
Nebraska	59%
Nevada	94%
New Hampshire	55%
New Jersey	133%
New Mexico	409%
New York	150%
North Carolina	52%
North Dakota	63%
Ohio	90%
Oklahoma	200%
Oregon	100%
Pennsylvania	200%
Rhode Island	191%
South Carolina	100%
South Dakota	56%
Tennessee	80%
Texas	28%
Utah	150%
Vermont	191%
Virginia	31%
Washington	200%
West Virginia	35%
Wisconsin	191%
Wyoming	55%

Note: Data as of January 2008. The Federal Poverty Level (FPL) for a family of three in 2008 was $17,600 per year.
Source: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

— — — Best state in column
——— Worst state in column

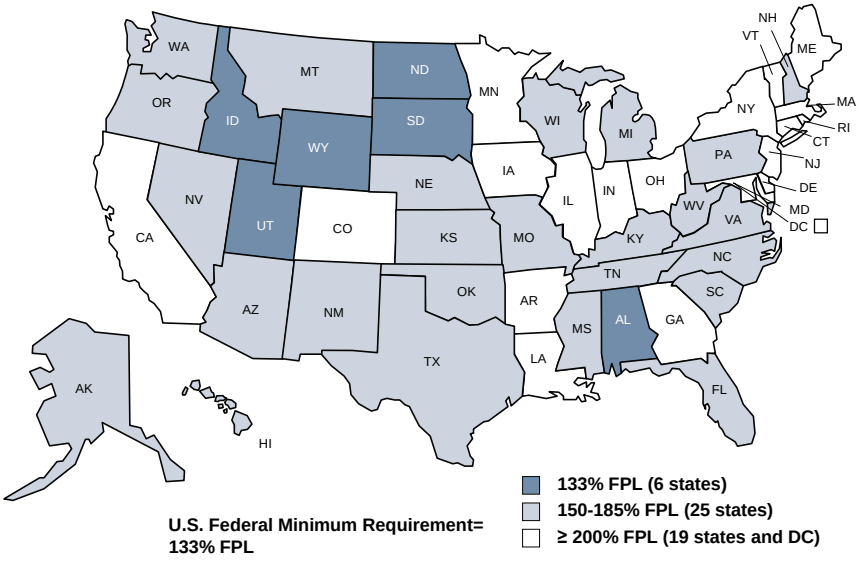
MEDICAID/SCHIP INCOME ELIGIBILITY FOR PREGNANT WOMEN

Medicaid is a major source of financing for maternity care in the U.S., paying for approximately four out of ten births nationally.[81] Medicaid coverage promotes access to prenatal care for beneficiaries, who tend to be younger, poorer, and in worse health than the general population, reducing their risk for problems such as low birthweight babies and other health complications. Under federal law, states must provide Medicaid for pregnancy-related care to pregnant women with incomes at or below 133% of the FPL. States have the option of going beyond the federal law and expanding eligibility to pregnant women with incomes up to 185% of the FPL and beyond. States may expand Medicaid coverage for pregnant women above the 185% threshold by disregarding a set amount of each applicant's income, such as the first $50.

Infants who are born to women on Medicaid are guaranteed coverage for the full year. In contrast, the mother is covered through 60 days postpartum or through the last day of the month in which the 60 days expire unless she qualifies through another pathway such as a parent. If she doesn't qualify for Medicaid, she often becomes uninsured.

- The variation was smaller for Medicaid income eligibility for pregnant women than for working parents. It ranged from 133% FPL (the Federal minimum requirement) in six states (Alabama, Idaho, North Dakota, South Dakota, Utah, and Wyoming) to 300% of the FPL in the District of Columbia.
- Most states expanded eligibility to at least 185% FPL; only four states (Connecticut, Maryland, Minnesota, and Rhode Island) and the District of Columbia exceeded 200% FPL.

FIGURE 4.6. Medicaid/SCHIP Income Eligibility for Pregnant Women as a Percent of Federal Poverty Level, by State



Note: Data as of January 2008. The Federal Poverty Level (FPL) for a family of three in 2008 was $17,600 per year.
Source: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

TABLE 4.6. Medicaid/SCHIP Income Eligibility for Pregnant Women, by State

State	Medicaid/SCHIP Income Eligibility for Pregnant Women as a Percent of Federal Poverty Level
United States	**133%**
Alabama	133%
Alaska	175%
Arizona	150%
Arkansas	200%
California	200%
Colorado	200%
Connecticut	250%
Delaware	200%
District of Columbia	300%
Florida	185%
Georgia	200%
Hawaii	185%
Idaho	133%
Illinois	200%
Indiana	200%
Iowa	200%
Kansas	150%
Kentucky	185%
Louisiana	200%
Maine	200%
Maryland	250%
Massachusetts	200%
Michigan	185%
Minnesota	275%
Mississippi	185%
Missouri	185%
Montana	150%
Nebraska	185%
Nevada	185%
New Hampshire	185%
New Jersey	200%
New Mexico	185%
New York	200%
North Carolina	185%
North Dakota	133%
Ohio	200%
Oklahoma	185%
Oregon	185%
Pennsylvania	185%
Rhode Island	250%
South Carolina	185%
South Dakota	133%
Tennessee	185%
Texas	185%
Utah	133%
Vermont	200%
Virginia	185%
Washington	185%
West Virginia	150%
Wisconsin	185%
Wyoming	133%

Note: Data as of January 2008. The Federal Poverty Level (FPL) for a family of three in 2008 was $17,600 per year.
Source: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

— — — Best state in column

——— Worst state in column

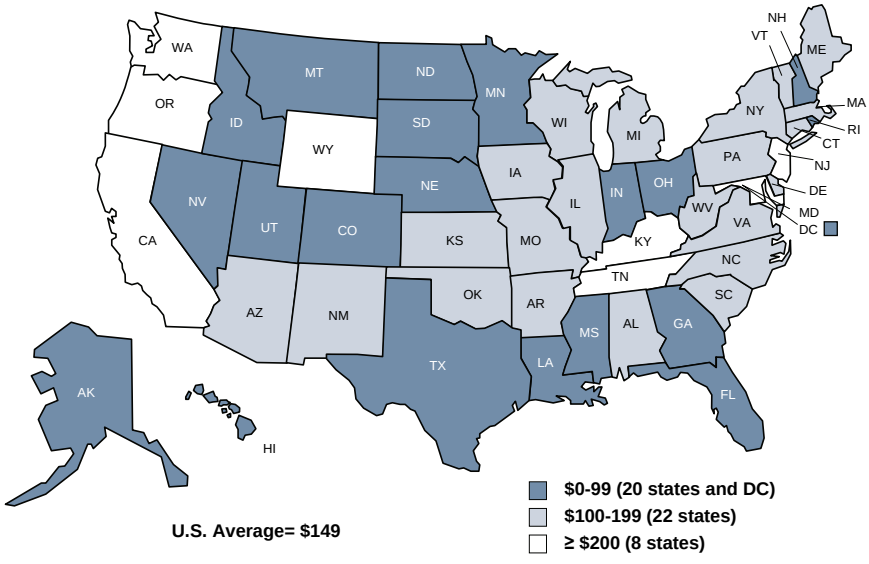
FAMILY PLANNING FUNDING

Access to contraceptive services is an important element to health care for women of reproductive age. Programs like Title X, the federally funded family planning program, and Medicaid provide low-income women with the financial means to obtain not only contraceptive services, but also screening for cervical cancer and sexually transmitted infections. For many women, a family planning provider is their only source of care.

This indicator measures the amount of per capita funding available in a state for family planning services for low-income women who are considered in need of contraceptive services. Expenditures allocated by the state include state-only funds and all non-Medicaid federal funds including the Maternal and Child Health (MCH) and Social Services block grants, and Temporary Assistance for Needy Families (TANF) for contraceptive services, outreach and education. These appropriations are classified as state allocations because the state has discretion over whether such funding is spent on family planning services or for other health care services. Women needing publicly-supported contraceptive services and supplies are defined as those in need of such services who either are aged 20–44 and have a family income that is below 250% FPL ($50,000 for a family of four in 2006) or are younger than 20. The indicator is adjusted for the health care cost of living in each state.

- State funding for women who were in need of publicly supported family planning services varied substantially, ranging from a low of $28 per woman in Hawaii to a high of $368 per woman in Oregon.
- The U.S. average was $149 per woman. Twenty states and the District of Columbia contributed less than $100 to family planning funding per woman in need, while eight states (California, Kentucky, Maryland, New Jersey, Oregon, Tennessee, Washington, and Wyoming) contributed more than $200.

FIGURE 4.7. Family Planning Funding for Women with Incomes Below 250% of Federal Poverty Level, by State



Sources: Calculations based on Sonfield A, Arlich C & Gold R. *Public funding for family planning, sterilization and abortion services, FY 1980-2006.* 2008.; Guttmacher Institute. *Women in need of contraceptive services and supplies, 2006.* 2008.

TABLE 4.7. Family Planning Funding for Women with Incomes Below 250% FPL, by State

State	Family Planning Funding Per Woman in Need
All States	**$149**
Alabama*	$166
Alaska	$71
Arizona*	$124
Arkansas*	$154
California*	$218
Colorado	$46
Connecticut	$164
Delaware*	$181
District of Columbia	$53
Florida*	$92
Georgia	$47
Hawaii	$28
Idaho	$99
Illinois*	$107
Indiana	$40
Iowa*	$123
Kansas	$138
Kentucky	$359
Louisiana*	$95
Maine	$134
Maryland*	$252
Massachusetts	$143
Michigan*	$102
Minnesota*	$64
Mississippi*	$95
Missouri*	$121
Montana	$72
Nebraska	$73
Nevada	$55
New Hampshire	$65
New Jersey	$223
New Mexico*	$111
New York*	$175
North Carolina*	$159
North Dakota	$80
Ohio	$72
Oklahoma*	$187
Oregon*	$368
Pennsylvania*	$170
Rhode Island*	$84
South Carolina*	$176
South Dakota	$61
Tennessee	$224
Texas*	$81
Utah	$34
Vermont	$130
Virginia*	$197
Washington*	$326
West Virginia	$125
Wisconsin*	$199
Wyoming	$322

Note: * States with Medicaid family planning waiver programs. Data as of 2006. The Federal Poverty Level (FPL) for a family of three in 2006 was $16,600 per year.
Source: Calculations based on Sonfield A, Arlich C & Gold R. *Public funding for family planning, sterilization and abortion services, FY 1980-2006* . 2008.; Guttmacher Institute. *Women in need of contraceptive services and supplies, 2006* . 2008.

— — — Best state in column

——— Worst state in column

ABORTION ACCESS

Abortion rates have been declining among all racial and ethnic groups; however, approximately one-fifth of pregnancies in the U.S. end in abortion each year. In recent years, state and federal policies have increasingly restricted access to abortion services for women. Certain policies have a disproportionate effect on low-income women and women of color. While there are many policies that states can enact to restrict abortion access, this report looks at three that are likely to have a greater impact on women of color.

At the federal level, the Hyde Amendment explicitly bans the use of federal funds to pay for abortions unless the pregnancy is a result of rape or incest or if the pregnancy is considered to be a threat to the life of the mother. In the case of Medicaid beneficiaries, states can use their own funding to cover other "medically necessary" abortions, usually to protect the physical or mental health of the women.

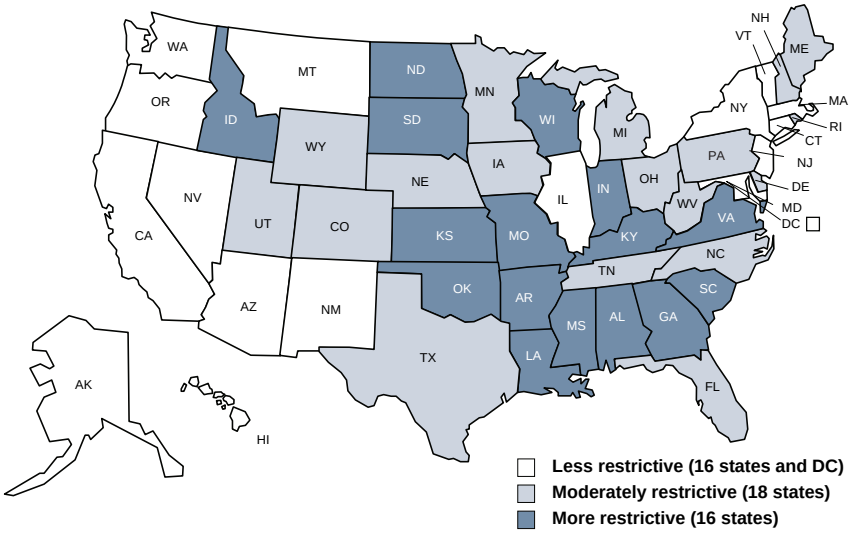
The lack of an abortion provider within easy traveling distance is a critical barrier for many women. These women must often travel long distances to obtain this medical service, which can place an undue burden on low-income women.

Another barrier that has a disproportionate effect on low-income women is a mandatory waiting period that requires women to wait some period of time between state-mandated counseling and the abortion procedure. These waiting period results in multiple trips for women, who then have to take extra time off from work, arrange for child care, and pay higher transportation costs.

To construct this composite index, each of the three component indicators (mandatory waiting period, no use of state-only funds to cover "medically necessary" abortions, and percentage of women who live in counties without an abortion provider) was rated on a scale of 0 to 1 and assigned a weight of 1/3.

- State policies affecting access to abortion were less restrictive in the Pacific Western and Northeastern regions. In Hawaii, the least restrictive state, the state provided Medicaid funding to low-income women for "medically necessary" abortions, there was no waiting period, and all women lived in counties with an abortion provider. California, New York, Connecticut and New Jersey also had less restrictive policies regarding access to abortion.
- Southern states tended to have more restrictive policies affecting access to abortion. Mississippi was the most restrictive in that it did not use state-only funds for "medically necessary" abortions for Medicaid recipients, it had a waiting period, and 91% of women lived in counties without an abortion provider. South Dakota, Arkansas, North Dakota, and Kentucky also had more restrictive policies regarding access to abortion.
- Seventeen states used their own funds to cover all or most "medically necessary" abortions for Medicaid beneficiaries. Thirty-two states and the District of Columbia followed federal Medicaid abortion funding restrictions, which limit publicly funded abortion to cases of rape, incest or life endangerment. South Dakota covered abortions only in cases of life endangerment, which does not comply with the minimum federal requirements under the Hyde Amendment.
- Nationally, 35% of women lived in counties without an abortion provider. The percentage of women who lived in counties without an abortion provider ranged from 0% in Hawaii to 96% in Wyoming.
- Twenty-eight states required women to wait a specified amount of time (usually 24 hours) between counseling and the abortion procedure. This mandatory waiting period policy was not in effect however in four of these states (Delaware, Massachusetts, Montana, and Tennessee) pending legal review.

FIGURE 4.8. Abortion Access, by State



Note: Composite measure of state policies on mandatory waiting periods, Medicaid funding and the availability of abortion providers. States are categorized based on total scores in Table 4.8 as follows: 0.00-0.38 = less restrictive; 0.39-0.85= moderately restrictive; 0.86-0.97 = more restrictive.
Sources: Guttmacher Institute. *Overview of State Abortion Law.* 2008; Jones R et al. Abortion in the United States: Incidence and Access to Services, 2005. *Perspectives on Sexual and Reproductive Health*, 40(1). 2008.

TABLE 4.8. Abortion Access, by State

State	Mandatory Waiting Period for Abortion: 1=Yes, 0=No (Weight:1/3)	Medicaid Funding of Abortion: 1=No, 0=Yes (Weight:1/3)	% of Women in Counties with No Abortion Provider (Weight:1/3)	Total Score* (0=Least Restrictive, 1=Most Restrictive)
Alabama	Yes	No	61%	0.87
Alaska	No	Yes	15%	0.05
Arizona	No	Yes	16%	0.05
Arkansas	Yes	No	79%	0.93
California	No	Yes	4%	0.01
Colorado	No	No	23%	0.41
Connecticut	No	Yes	10%	0.03
Delaware	No	No	18%	0.39
District of Columbia	No	No	0%	0.33
Florida	No	No	20%	0.40
Georgia	Yes	No	62%	0.87
Hawaii	No	Yes	0%	0.00
Idaho	Yes	No	68%	0.89
Illinois	No	Yes	34%	0.11
Indiana	Yes	No	63%	0.88
Iowa	No	No	56%	0.52
Kansas	Yes	No	57%	0.86
Kentucky	Yes	No	77%	0.92
Louisiana	Yes	No	62%	0.87
Maine	No	No	46%	0.49
Maryland	No	Yes	19%	0.06
Massachusetts	No	Yes	7%	0.02
Michigan	Yes	No	33%	0.78
Minnesota	Yes	Yes	62%	0.54
Mississippi	Yes	No	91%	0.97
Missouri	Yes	No	68%	0.89
Montana	No	Yes	49%	0.16
Nebraska	Yes	No	45%	0.82
Nevada	No	No	12%	0.37
New Hampshire	No	No	19%	0.40
New Jersey	No	Yes	10%	0.03
New Mexico	No	Yes	47%	0.16
New York	No	Yes	7%	0.02
North Carolina	No	No	48%	0.49
North Dakota	Yes	No	75%	0.92
Ohio	Yes	No	51%	0.84
Oklahoma	Yes	No	57%	0.86
Oregon	No	Yes	26%	0.09
Pennsylvania	Yes	No	40%	0.80
Rhode Island	No	No	39%	0.46
South Carolina	Yes	No	72%	0.91
South Dakota	Yes	No	78%	0.93
Tennessee	No	No	59%	0.53
Texas	Yes	No	35%	0.78
Utah	Yes	No	55%	0.85
Vermont	No	Yes	24%	0.08
Virginia	Yes	No	57%	0.86
Washington	No	Yes	14%	0.05
West Virginia	Yes	Yes	84%	0.61
Wisconsin	Yes	No	63%	0.88
Wyoming	No	No	96%	0.65

Note: *Composite measure of state policies on mandatory waiting periods, Medicaid funding and the availability of abortion providers.
Source: Guttmacher Institute. *Overview of State Abortion Law*. 2008; Jones R et al. Abortion in the United States: Incidence and Access to Services. *Perspectives on Sexual and Reproductive Health* , 40(1). 2008.

— — — Best state in column

——— Worst state in column