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Improving Health Care Quality

SCORECARD
JULY 18, 2024

2024 State Scorecard on Women's Health and Reproductive Care



▲ Illustration by Rose Wong

TOPLINES

Where a woman lives matters to her health: U.S. states vary widely in access to care, quality of care, and health outcomes for women

Gaps in women's health and care could widen further, especially for women of color and those with low incomes who live in states that have restricted access to reproductive health care

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Scorecard Highlights

- Massachusetts, Vermont, and Rhode Island top the rankings for the *2024 State Scorecard on Women's Health and Reproductive Care*, which is based on 32 measures of health care access, quality, and health outcomes. The lowest performers were Mississippi, Texas, Nevada, and Oklahoma.
- Deaths from all causes among women of reproductive age — 15 to 44 — were highest in southeastern states. Causes of death include pregnancy and other preventable causes such as substance use, COVID-19, and treatable chronic conditions.
- The highest maternal death rates were in Tennessee, Mississippi, and Louisiana. Vermont, California, and Connecticut had the lowest rates. Nationally, rates were highest for Black and American Indian and Alaska Native (AIAN) women.
- Mental health conditions are the most frequently reported cause of preventable pregnancy-related death, including deaths by suicide and overdoses related to substance use disorders. States that screened for postpartum depression at the highest rates also had lowest rates of postpartum depression.
- Among women of reproductive age (ages 15–44), those in Texas, Georgia, and Oklahoma were uninsured at the highest rates; those in Massachusetts, the District of Columbia, and Vermont had the lowest uninsured rates. Women in states that had not expanded Medicaid eligibility were among those most at risk of lacking coverage.

- The U.S. Supreme Court decision overturning *Roe v. Wade* in June 2022 has significantly altered both access to reproductive health care services and how providers are able to treat pregnancy complications in the 21 states that ban or restrict abortion access.

SECTIONS

01 Health Outcomes

02 Health Care Quality and Prevention

03 Coverage, Access, and Affordability

Overview

The health of women in the United States is in a perilous place. Deaths from preventable causes are on the rise and deep inequities persist, leading to stark racial differences in maternal mortality and deaths from breast and cervical cancers. Despite a small rebound in women's life expectancy in 2022, it remains at its lowest since 2006.¹

These troubling health trends are occurring while women are experiencing the consequences of state policy choices and judicial decisions that limit their access to the full range of health services and reproductive care. Ten states have yet to expand eligibility for Medicaid, leaving nearly 800,000 women uninsured.² A highly variable state-by-state approach to the unwinding of pandemic-era Medicaid coverage has left millions of women either newly uninsured or with significant gaps in their coverage.³

These coverage losses are not only interfering with women's access to care, but they're also leaving providers that serve low-income women at risk of closure. A recent survey found that 95 percent of community health centers, which care for 40 percent of low-income women nationwide — almost half of whom are covered by Medicaid — reported having patients who were disenrolled.⁴

The 2022 U.S. Supreme Court case overturning *Roe v. Wade* has further fractured women's health care access and dramatically affected the ability of providers to treat pregnancy complications. In the wake of the decision in *Dobbs v. Jackson Women's Health Organization*, 21 states have tightened or imposed new limits or bans on abortion.⁵ Florida's six-week ban went into effect in April 2024, severely limiting abortion access for women across the South, since all southern states now ban or restrict abortion. Even prior to *Dobbs*, most of these states had few maternity care providers; higher rates of maternal mortality, especially among women of color; and wide racial and ethnic disparities in their

health systems.⁶ In 2022, the year of the *Dobbs* decision, residents of more than one-third of U.S. counties had little or no access to maternity care.⁷

2024 State Rankings on Health System Performance for Women's Health and Reproductive Care

Which states lead the overall rankings?

Massachusetts, Vermont, Rhode Island, Connecticut, New Hampshire

Which states are ranked at the bottom?

Mississippi, Texas, Nevada, Oklahoma, Arkansas

What are the leading states by region?

(See *Regional Comparisons in the Scorecard Methods* for the list of states in each region)

- Great Lakes Wisconsin
- Mid-Atlantic District of Columbia
- New England Massachusetts
- Plains Minnesota
- Rocky Mountain Colorado
- Southeast Virginia
- Southwest New Mexico
- West Hawaii

Tighter limits and additional bans on abortion are certain to drive more maternal and reproductive health care providers to shut down or leave their states, deepening the crisis of access to maternity care. Abortion bans threaten American’s future access to care across all medical specialties; in fact, since 2022, medical residency applications in states with bans have declined by more than those in other states.⁸

Women’s access to contraception and infertility treatments is also at risk. In February 2024, Alabama’s supreme court gave stored embryos the same legal protections as children. This ruling disrupted the care of women undergoing in vitro fertilization (IVF) treatment in Alabama until the state’s governor signed legislation in March providing civil and criminal immunity to IVF providers. In some states, widespread misinformation and misunderstanding could also lead policymakers to place limits on contraception in the new landscape created by the *Dobbs* decision.⁹

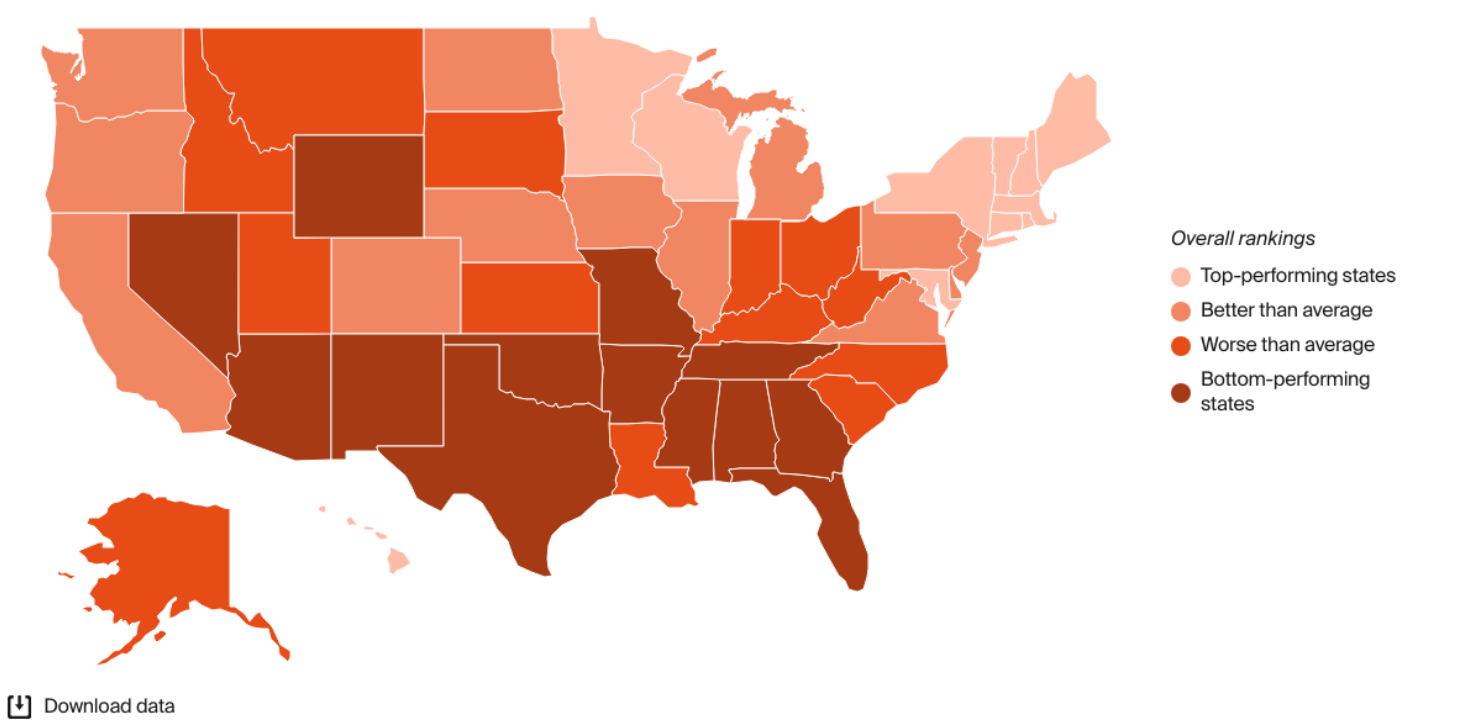
Clearly, women's health is under threat. That's why the Commonwealth Fund has developed the first-ever state scorecard to track trends in women's health over time and document how policy choices and judicial decisions may impact women's access to timely health care.

Our *State Scorecard on Women's Health and Reproductive Care* uses the most recent data to assess how well the health care system is working for women in every U.S. state. We measured performance by 32 different metrics across three areas: health outcomes; health care quality and prevention; and coverage, access, and affordability. This report presents state rankings for each area.

Massachusetts is the best-performing health system for women overall, ranking among the top states on each of the three dimensions of health system performance. **Vermont, Rhode Island, Connecticut,** and **New Hampshire** rounded out the top five.

The lowest-ranked states overall are **Mississippi, Texas, Nevada, Oklahoma,** and **Arkansas**. The highest-ranked states are concentrated in New England, the Mid-Atlantic, and the northern Midwest. The lowest-ranked states fan out across the Southeast and Southwest.

Massachusetts, Vermont, and Rhode Island top the overall rankings of health system performance for women.



Data: Overall performance scores from the Commonwealth Fund 2024 State Scorecard on Women's Health and Reproductive Care.

Source: Sara R. Collins et al., *2024 State Scorecard on Women's Health and Reproductive Care* (Commonwealth Fund, July 2024). <https://doi.org/10.26099/6gr0-t974>

Key Scorecard Findings

Health Outcomes

HOW STATES RANK ON Women's Health and Reproductive Care Outcomes

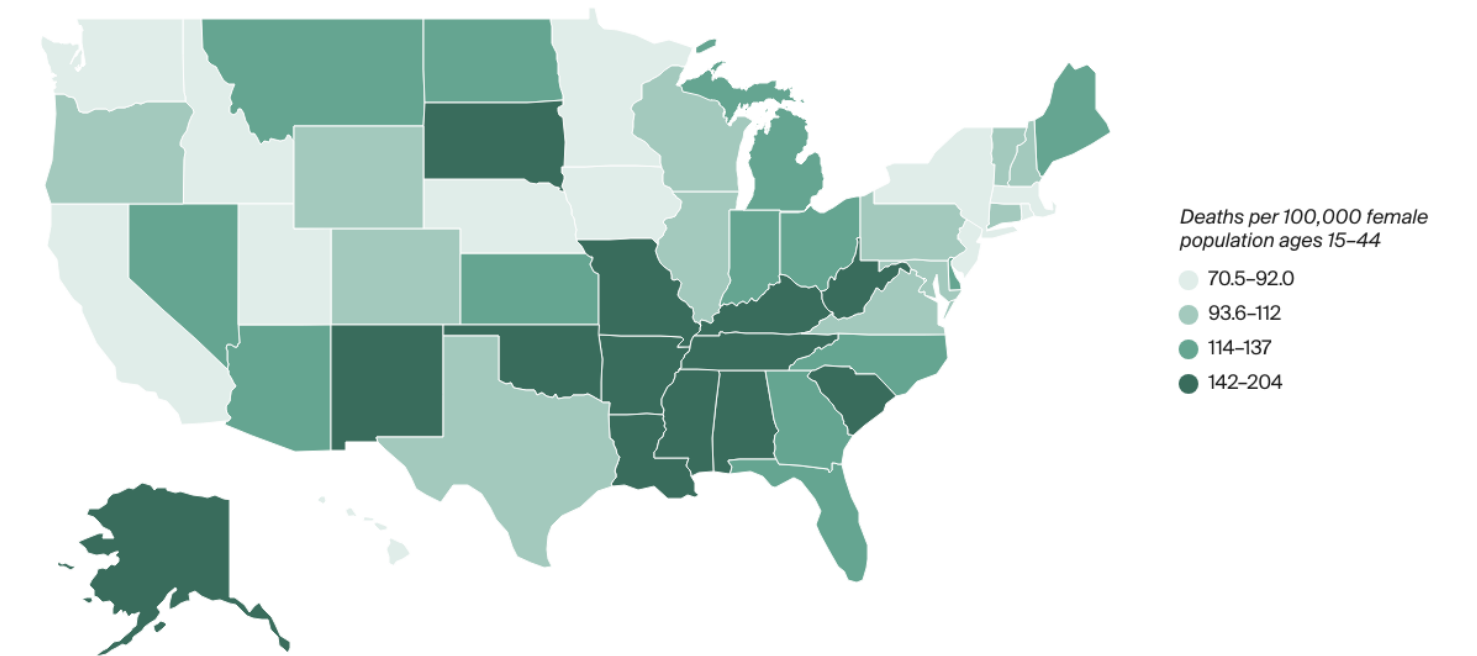
Click on the headers to sort the ranking.
Scroll to see all 50 states and D.C.

Rank	State
1	Massachusetts
2	New Jersey
3	Connecticut
4	Vermont
5	Hawaii
6	New York
7	Minnesota
8	New Hampshire
9	Rhode Island
9	Washington

For health outcomes, we measured all-cause mortality, maternal and infant mortality, preterm birth rates, syphilis among women of reproductive age, infants born with congenital syphilis, self-reported health status, postpartum depression, breast and cervical cancer deaths, poor mental health, and intimate partner violence. The top-performing states are Massachusetts, New Jersey, and Connecticut, while Mississippi, Arkansas, and West Virginia rank lowest.

A key measure of health outcomes is the all-cause mortality rate for women of reproductive age, 15 to 44. The top causes of mortality for women in this age group include those from preventable causes such as pregnancy-related, substance use, breast and cervical cancer, and COVID-19.¹⁰ In 2022, mortality for women of reproductive age was higher in the Southeast than in any other region. The death rate ranged from 203.6 per 100,000 in West Virginia to 70.5 in Hawaii.

All-cause mortality for women of reproductive age is highest in southeastern states.



Download data

Data: CDC National Vital Statistics System (NVSS): WONDER, 2022.

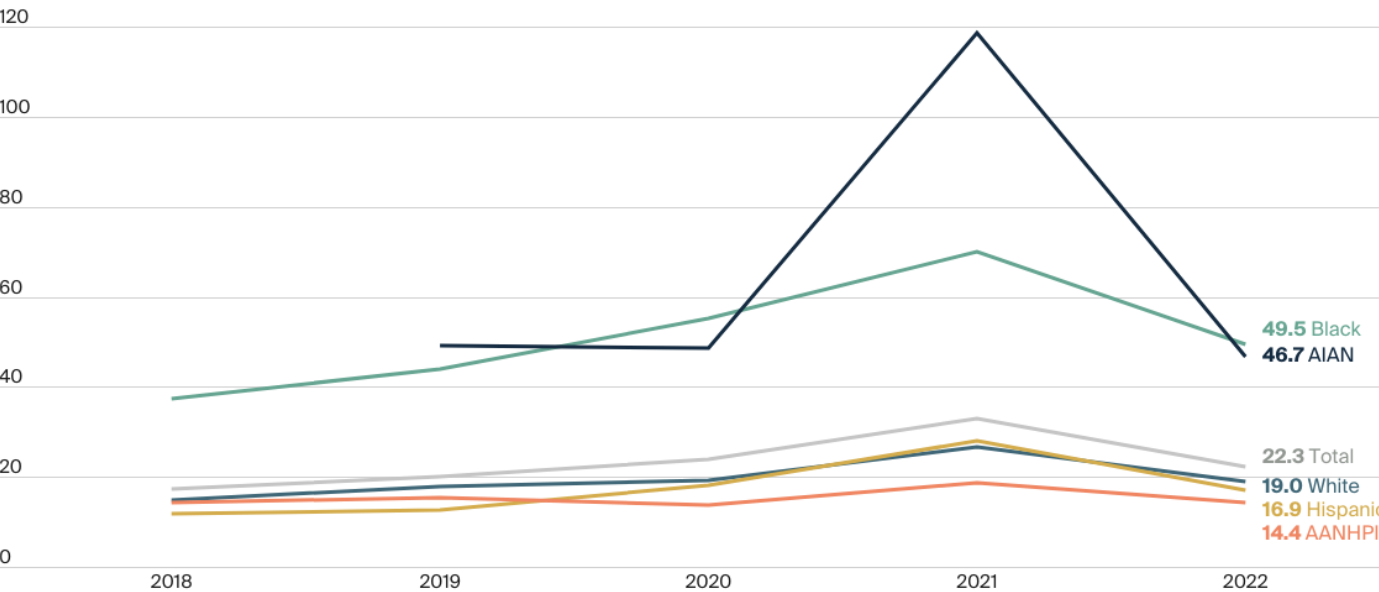
Source: Sara R. Collins et al., 2024 State Scorecard on Women's Health and Reproductive Care (Commonwealth Fund, July 2024). <https://doi.org/10.26099/6gr0-t974>

Inadequate access to health services before, during, and after pregnancy, combined with disparities in socioeconomic status, underlying health, and quality of care, have helped drive the maternal mortality rate in the U.S. higher than that of other high-income countries.¹¹ Maternal death rates are highest among Black and American Indian and Alaska Native (AIAN) people,¹² as both populations were hit hard by the COVID-19 pandemic, especially AIAN women. Despite historically lower rates of maternal mortality, Hispanic women also experienced a rising maternal death rate during the pandemic.¹³

Research shows that in addition to the effects of COVID-19 infections, the pandemic exacerbated existing barriers to maternal care, including reductions in transportation services and childcare.¹⁴ Maternal mortality rates fell back to prepandemic levels in 2022, but the highly elevated rates among Black and AIAN women persist.

The maternal mortality rate nearly doubled between 2018 and 2022, with rates for Black and American Indian and Alaska Native women increasing the most.

Maternal mortality rate per 100,000 live births, 2018–2022



Download data

Note: Maternal deaths include those assigned to ICD-10 codes A34, O00–O95, and O98–O99 and occur while pregnant or within 42 days of being pregnant. Rates shown are for American Indian/Alaska Native (AIAN; non-Hispanic); Asian American, Native Hawaiian and Pacific Islander (AANHPI; non-Hispanic); Black (non-Hispanic); white (non-Hispanic); and Hispanic (any race) people, based on information from decedent's death certificate. 2018 AIAN rate is not available because of CDC data suppression standards for small numbers of deaths. AA and NHPI data are combined because NHPI data alone are not available for 2018–2022 because of CDC data suppression standards for small numbers of deaths.

Data: Donna L. Hoyert, *Health E-stat: Maternal Mortality Rates in the United States, 2022* (National Center for Health Statistics, May 2024); and authors' calculations using data from the National Vital Statistics System (NVSS), Natality and Mortality, via CDC WONDER, 2018–2022.

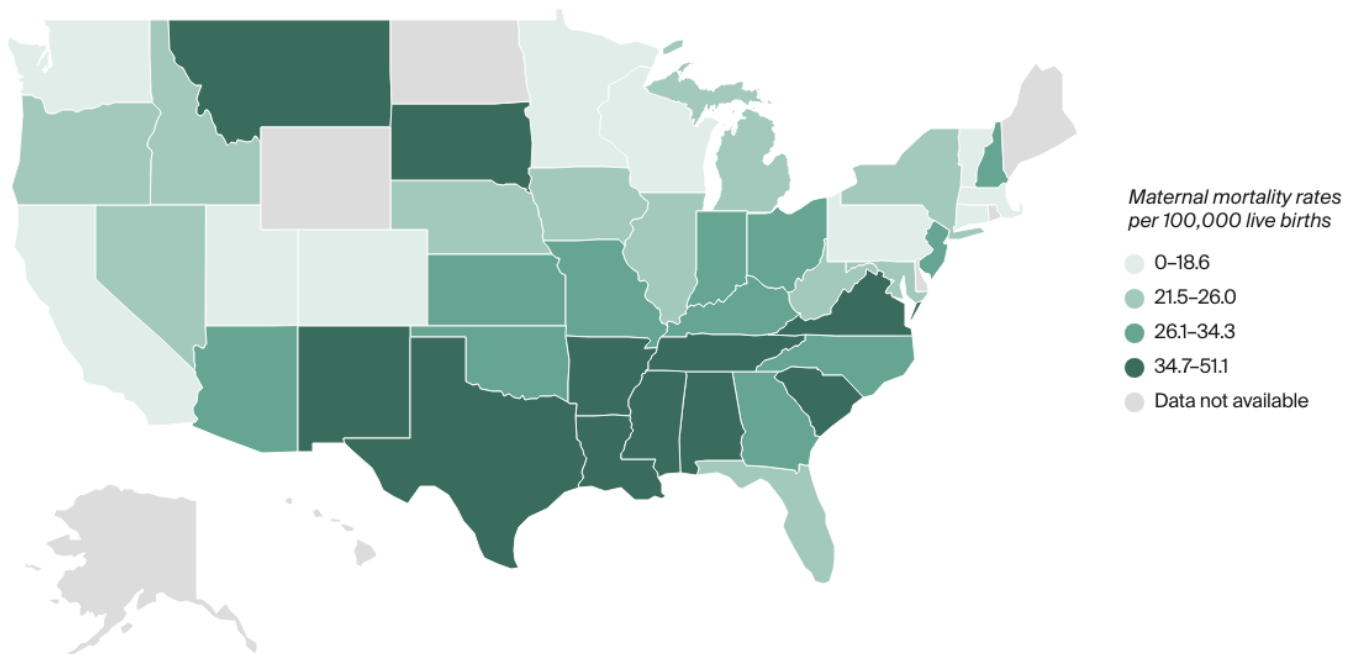
Source: Sara R. Collins et al., *2024 State Scorecard on Women's Health and Reproductive Care* (Commonwealth Fund, July 2024). <https://doi.org/10.26099/6gr0-1974>

The highest rates of maternal mortality can be found in the Mississippi Delta, which includes Arkansas, Louisiana, Mississippi, and Tennessee. A substantial percentage of

counties in all these states don't have a single hospital or birth center with obstetric providers offering obstetric care.¹⁵

These states also rank low on other potential contributors to maternal mortality: low rates of postpartum depression screening, high rates of low-risk cesarean births, and high uninsured rates prior to pregnancy. All four states had abortion restrictions prior to *Dobbs*, and they all now have full bans on abortion.

The highest rates of maternal mortality are in the Mississippi Delta region.



Download data

Data: CDC National Vital Statistics System (NVSS): WONDER, 2020–2022.

Source: Sara R. Collins et al., 2024 State Scorecard on Women's Health and Reproductive Care (Commonwealth Fund, July 2024). <https://doi.org/10.26099/6gr0-t974>

LESSONS FROM THE TOP STATES

Reducing Maternal Mortality

Top 3 States

The majority of pregnancy-related deaths are preventable. Prevention requires addressing mental health and cardiovascular conditions — the leading underlying causes of maternal death — and addressing health disparities.¹⁶ Nearly two-thirds of all pregnancy-related deaths occur after delivery, 22 percent during pregnancy, and 13 percent on the day of delivery.¹⁷

In our scorecard, states with the lowest rates of maternal mortality had:

- more maternity care providers (Vermont #2, Connecticut #3)
- fewer women with no prenatal care (Vermont #1, California #3, Connecticut #5)
- fewer women with no postpartum checkups (Vermont #1)
- fewer uninsured women ages 19–64 (Vermont #3).

All three states have expanded Medicaid, which is associated with lower rates of maternal mortality and smaller racial and ethnic disparities in maternal mortality and infant health outcomes.¹⁸ Medicaid expansion is also associated with greater use of essential preconception health services among women who become pregnant, such as preconception health counseling, and greater likelihood of taking folic acid prepregnancy.¹⁹

Efforts of the California Maternal Quality Care Collaborative (CMQCC), founded in 2006, helped reduce maternal mortality in the state. The California Department of Public Health surveils maternal mortality via the California Pregnancy Mortality Surveillance System and conducts case reviews in collaboration with the CMQCC and other stakeholders through the California Pregnancy-Associated Mortality Review. Case

reviews help to identify contributing factors and preventable causes of maternal mortality, such as hypertensive disorders of pregnancy, venous thromboembolism, and obstetric hemorrhage. These findings inform the quality improvement toolkits developed by CMQCC and utilized by hospitals within the state.²⁰

Research shows that community-based care provided through doulas, midwives, freestanding birth centers, group prenatal care, and pregnancy medical homes could also reduce maternal mortality.²¹

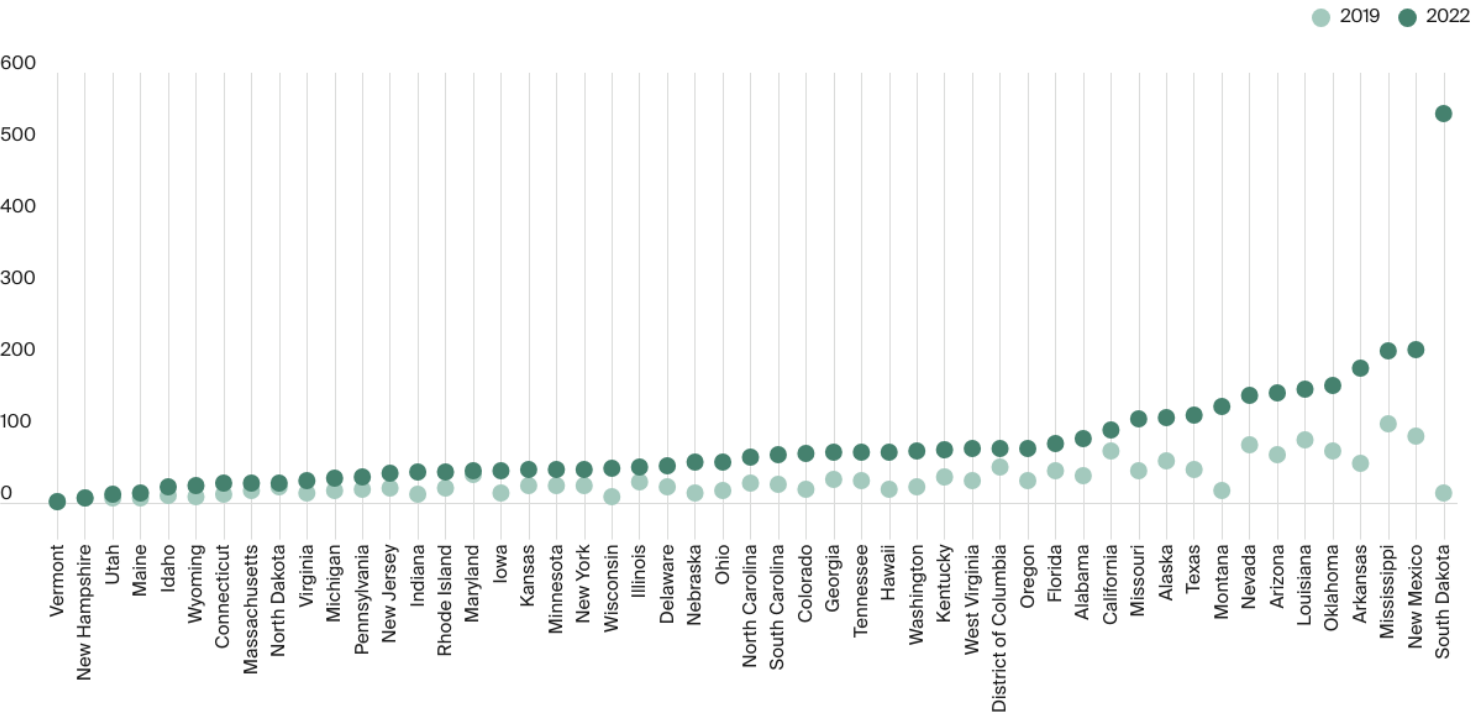
Syphilis infection among women of reproductive age has increased in nearly all states since 2019, with the highest rates in South Dakota, New Mexico, Mississippi, Arkansas, and Oklahoma. This continues an upward trend in syphilis infections among women that began in 2013.²² Rates are highest for AIAN women.²³ Research indicates that rising rates have been driven by nationwide increases in substance use, which may increase sexually risky behavior; limited access to care and health services for screening, diagnosis, and treatment, including screening during pregnancy; and isolated sexual networks within segregated communities.²⁴

Congenital syphilis rates have risen concomitantly with the growth in rates among women since 2013. Rates are highest for AIAN births.²⁵ Left untreated, syphilis during pregnancy can lead to severe complications, including increased risk of miscarriage, stillbirth, or early infant death. Newborns exposed to syphilis may experience long-term effects such as developmental delays and hearing loss.

To ensure timely detection and treatment, the U.S. Centers for Disease Control and Prevention recommends that all pregnant women be screened for syphilis early in pregnancy and again in the third trimester, as well as at birth for those at high risk. Some states, like California, recommend additional screening given the significant rise in infection rates.²⁶ Delays in accessing prenatal care can result in postponed screening and treatment. Early and effective treatment of syphilis during pregnancy can prevent adverse outcomes.²⁷

Syphilis infection rates among women of reproductive age have increased in nearly all states since 2019.

Syphilis prevalence, infection rate per 100,000 women ages 15–44



Download data

Data: CDC Sexually Transmitted Infections Surveillance, 2022.
Source: Sara R. Collins et al., 2024 State Scorecard on Women's Health and Reproductive Care (Commonwealth Fund, July 2024). <https://doi.org/10.26099/6gr0-t974>

Health Care Quality and Prevention

HOW STATES RANK ON Health Care Quality and Prevention for Women

Click on the headers to sort the ranking.
Scroll to see all 50 states and D.C.

Rank	State
1	Massachusetts
2	Rhode Island
3	Connecticut
4	Wisconsin
5	Maine
6	Vermont
7	North Dakota
8	District of Columbia
9	Maryland
9	Iowa

In the area of health care quality and prevention, we measured births by cesarean section for low-risk pregnancies, preventive care use, prenatal and postpartum care, and mental health screening. Massachusetts, Rhode Island, and Connecticut are the top-performing states, while Nevada, Mississippi, and Texas are the lowest-performing.

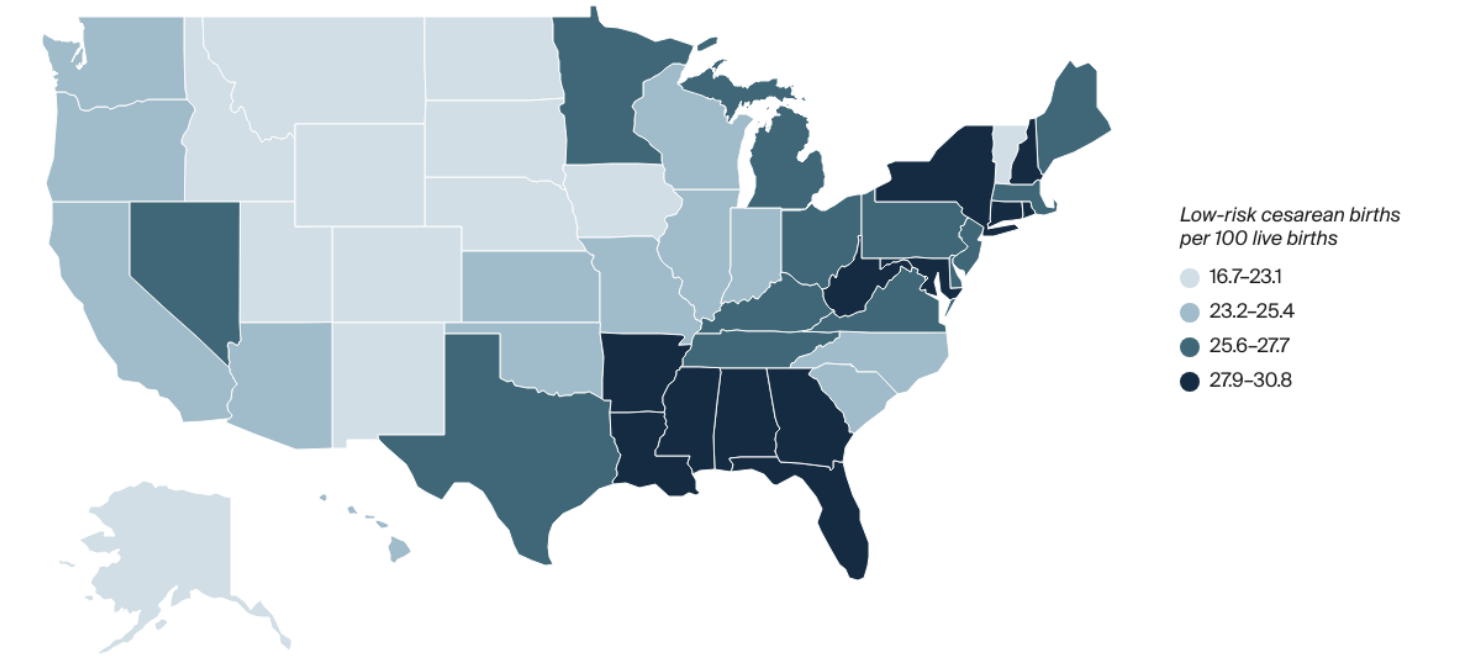
Nearly one-third of U.S. births are performed through a cesarean section surgery, or c-section. While cesarean delivery can be lifesaving in certain situations, the procedure is also associated with increased maternal morbidity and mortality, longer recovery, adverse outcomes in subsequent births, and negative impacts on infant health.²⁸ As such, high rates of cesarean births for low-risk pregnancies are a key indicator of lower-quality health care.

The U.S. Department of Health and Human Services (HHS) set a goal of 23.6 percent or lower c-sections for low-risk births by 2030.²⁹ It was 26.3 percent in 2022.

Low-risk cesarean births are performed at the highest rates in the Deep South and in a few states in the Northeast, including New York and Connecticut. A county-level analysis found that rates of c-sections in the South were high in both urban and rural areas.³⁰ This research also found that regions with the highest rates of cesarean births were home to more Black and Hispanic people.

Low-risk c-sections were also more prevalent among people with private insurance versus Medicaid; older women versus younger women; and those admitted to hospitals on weekdays, which may reflect scheduling preferences. National low-risk cesarean birth rates have dropped since their peak in 2009, possibly reflecting national and state quality initiatives.³¹

Low-risk cesarean births — a key indicator of lower quality maternal health care — is more common on the East Coast and in the southern U.S.



Download data

Note: Includes singleton, full term (37 completed weeks or more of gestation based on the obstetric estimate), vertex (not breech), cesarean deliveries to women having a first birth.

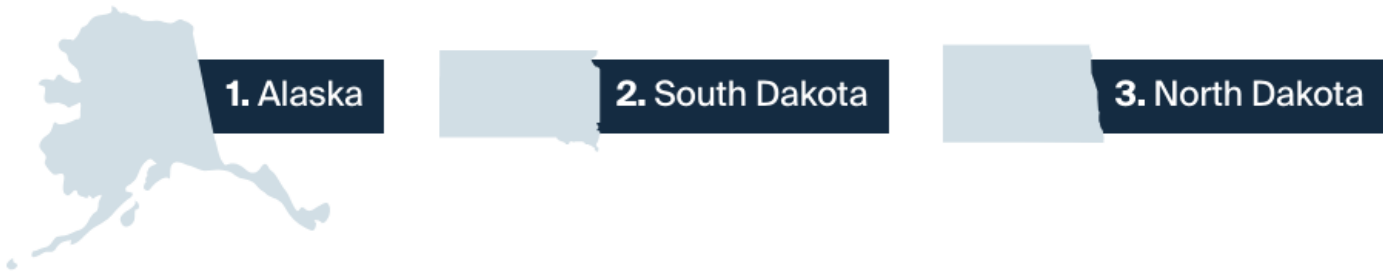
Data: Brady E. Hamilton, Joyce A. Martin, and Michelle J.K. Osterman, [Births: Provisional Data for 2022](#), Vital Statistics Rapid Release no. 28 (National Center for Health Statistics, June 2023).

Source: Sara R. Collins et al., *2024 State Scorecard on Women's Health and Reproductive Care* (Commonwealth Fund, July 2024). <https://doi.org/10.26099/6gr0-t974>

LESSONS FROM THE TOP STATES

Limiting Low-Risk Cesarean Births

Top 3 States



Rates of low-risk cesarean births are lowest in the West and Midwest and highest in the Northeast and in the Deep South, which has the highest rates in both urban and rural areas. While higher rates are associated with having commercial insurance, being Black or Hispanic, and of older maternal age, there is uncertainty about what's driving regional

differences. Studies have found lower rates of c-sections for low-risk pregnancies when they are managed by midwives and take place in freestanding birth centers.³²

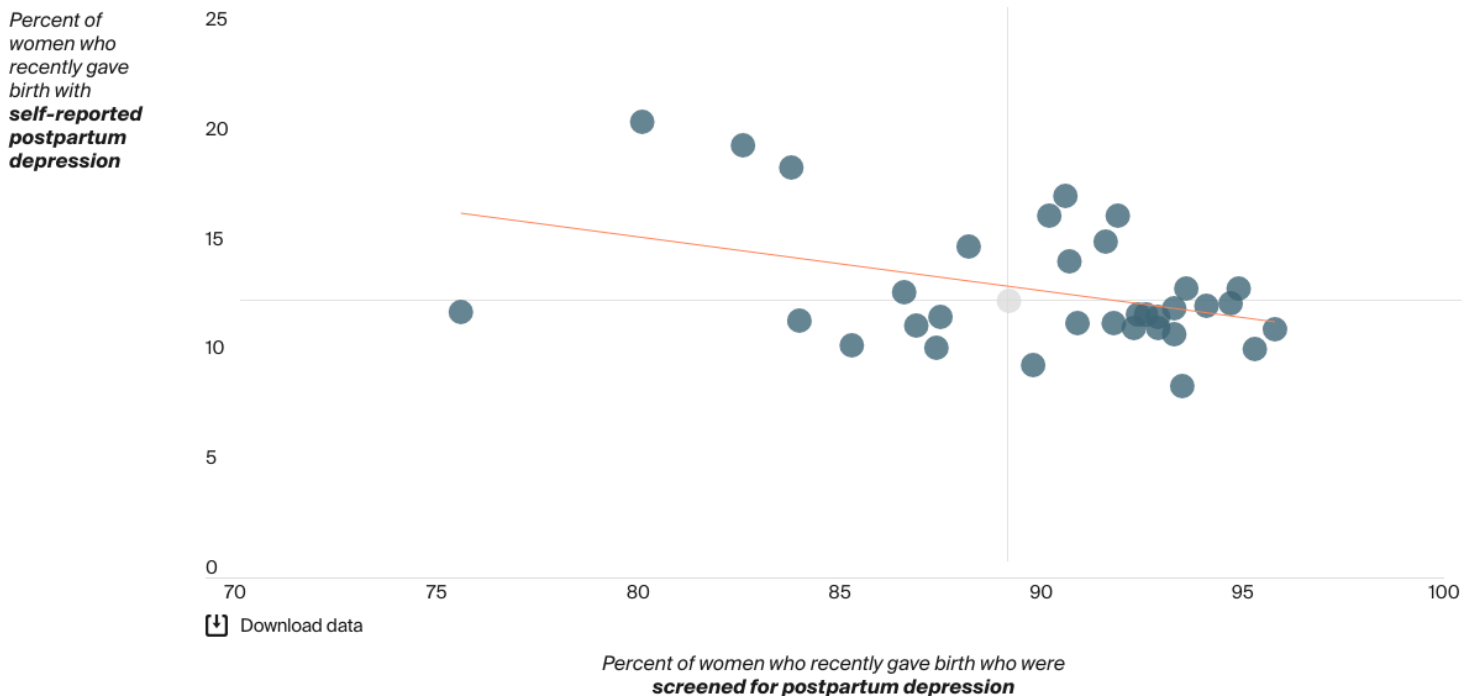
While Alaska ranks low on other measures of maternal health care and outcomes, it has the most midwife-attended births of any state.³³ One study found that low-risk cesarean delivery was associated with regional patterns in health care use overall — regions with higher Medicare spending had higher rates of low-risk cesarean births.³⁴ Another study found that hospitals with a “culture of care” that supports vaginal delivery have lower rates of low-risk c-sections.³⁵ National and state-level quality initiatives and changes in clinical guidance, such as HHS’s Healthy People 2030 goals and California Maternal Quality Care Collaborative, have been successful in lowering rates of low-risk c-sections across the board.³⁶

The most frequent cause of pregnancy-related deaths during or after a pregnancy are suicide, overdoses, and other deaths attributable to underlying mental health conditions.³⁷ In a recent study, mental health conditions were the leading cause of pregnancy-related deaths up to a year postpartum among white and Hispanic women.³⁸

Postpartum depression, a common mental health condition after childbirth, can make it difficult for mothers to take care of themselves and their babies. Screening for postpartum depression is an important preventive tool. In June 2023, the American College of Obstetricians and Gynecologists released new recommendations to screen for depression at least twice during pregnancy and at postpartum visits.³⁹ Enhanced screening, support, and treatment before, during, and after pregnancy are key to improving maternal health outcomes.

Southeastern states, including Mississippi, Arkansas, and Alabama, had lower rates of depression screening for women who recently gave birth and higher rates of self-reported postpartum depression. Vermont, Massachusetts, and Minnesota had higher-than-average rates of screening and lower-than-average rates of self-reported postpartum depression.

States with higher rates of postpartum depression tend to also have lower rates of postpartum depression screening.



Notes: Crossbars set at the observed U.S. rate. Orange line is the correlation between the two indicators; the Spearman correlation coefficient ($r_s = -0.29$) suggests a weak to moderate correlation. Data not available in all states.

Data: [Pregnancy Risk Assessment Monitoring System \(PRAMS\) automated research file](#), 2021.

Source: Sara R. Collins et al., *2024 State Scorecard on Women's Health and Reproductive Care* (Commonwealth Fund, July 2024). <https://doi.org/10.26099/6gr0-t974>

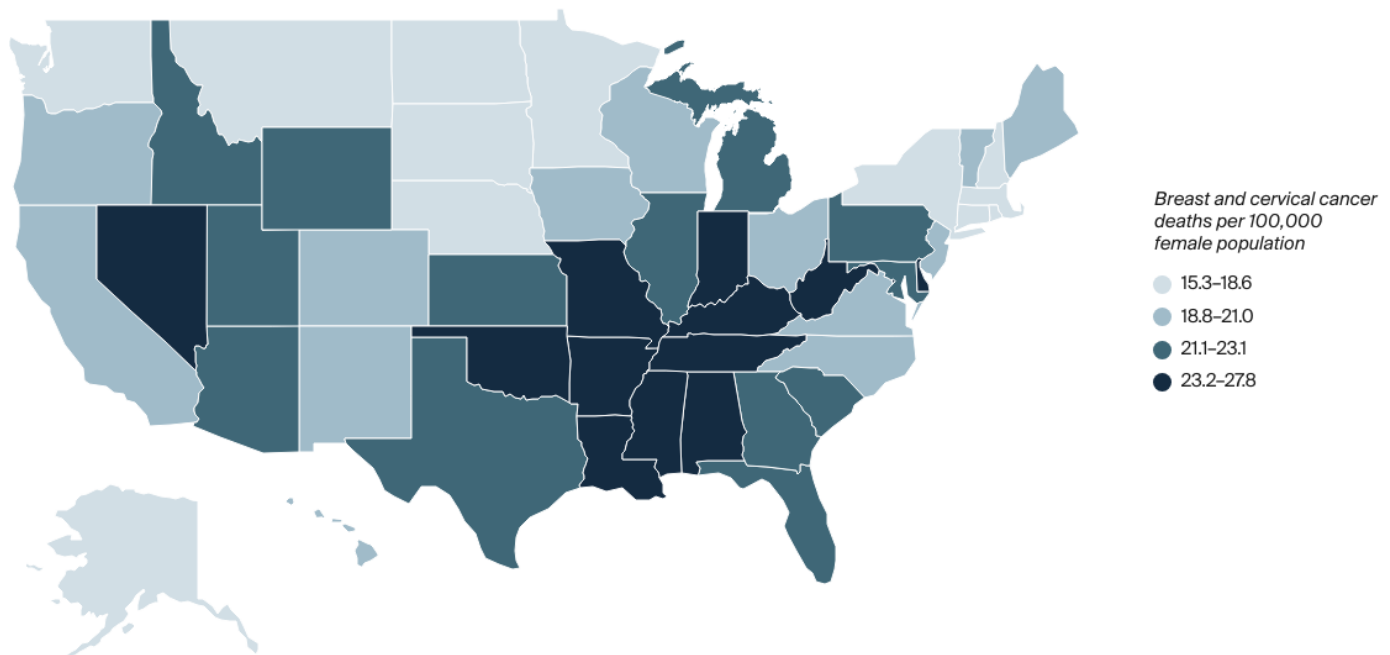
Deaths from breast and cervical cancer are considered preventable and treatable with timely screening and health care. There is significant regional variation in death rates from both cancers. States with among the highest rates are clustered in the Southeast. Northeastern states generally have the highest breast and cervical cancer screening rates and the lowest mortality rates from these cancers; southern states tend to have higher-than-average mortality from these cancers and lower screening rates.

Significant inequities exist in breast and cervical cancer rates despite similar or higher screening rates among Black women.⁴⁰ Black women are more likely to be up to date on screening tests for breast cancer than white women and less likely to be diagnosed with breast cancer, but they are more likely to die from the disease. A combination of factors account for the higher breast cancer mortality that Black women experience, including a lower likelihood of adequate follow-up screening and treatment from health systems, poorer quality of care after an abnormal test, and diagnoses being made at a more advanced

stage.⁴¹ Research has found that Black and Hispanic women have longer gaps between an abnormal mammogram and diagnostic follow-up than do white women.⁴²

Black women are similarly more likely to die from cervical cancer than white women. All women experience delays in follow-up care after abnormal cervical cancer screens, but Black women experience this at the highest rate.⁴³

Breast and cervical cancer deaths are highest in southern states.



Download data

Data: CDC WONDER, 2022.

Source: Sara R. Collins et al., *2024 State Scorecard on Women's Health and Reproductive Care* (Commonwealth Fund, July 2024). <https://doi.org/10.26099/6gr0-t974>

One reason women may not get recommended follow-up tests after an abnormal cancer screen is cost.⁴⁴ While the Affordable Care Act (ACA) requires all private and public insurance plans to cover mammograms and cervical cancer screenings without copayments, the same does not apply to follow-up screenings like ultrasounds and colposcopies.⁴⁵

More rigorous collection of self-reported data on race and ethnicity in medical records and more research that includes Black, Hispanic, and AIAN women could shed more light on the wide disparities in cancer outcomes and aid in the development of targeted policies to close the gap.⁴⁶

Coverage, Access, and Affordability

HOW STATES RANK ON Health Coverage, Access, and Affordability for Women

Click on the headers to sort the ranking.
Scroll to see all 50 states and D.C.

Rank	State
1	Vermont
2	District of Columbia
3	Maine
4	Rhode Island
5	Hawaii
6	Massachusetts
7	New Hampshire
8	Michigan
9	Connecticut
9	New York

In the area of coverage, access, and affordability, we measured insurance coverage, usual source of care, cost-related problems getting health care, and system capacity for reproductive health services. The top-ranked states are Vermont, the District of Columbia, and Maine; the lowest-ranked are Texas, Georgia, and Nevada.

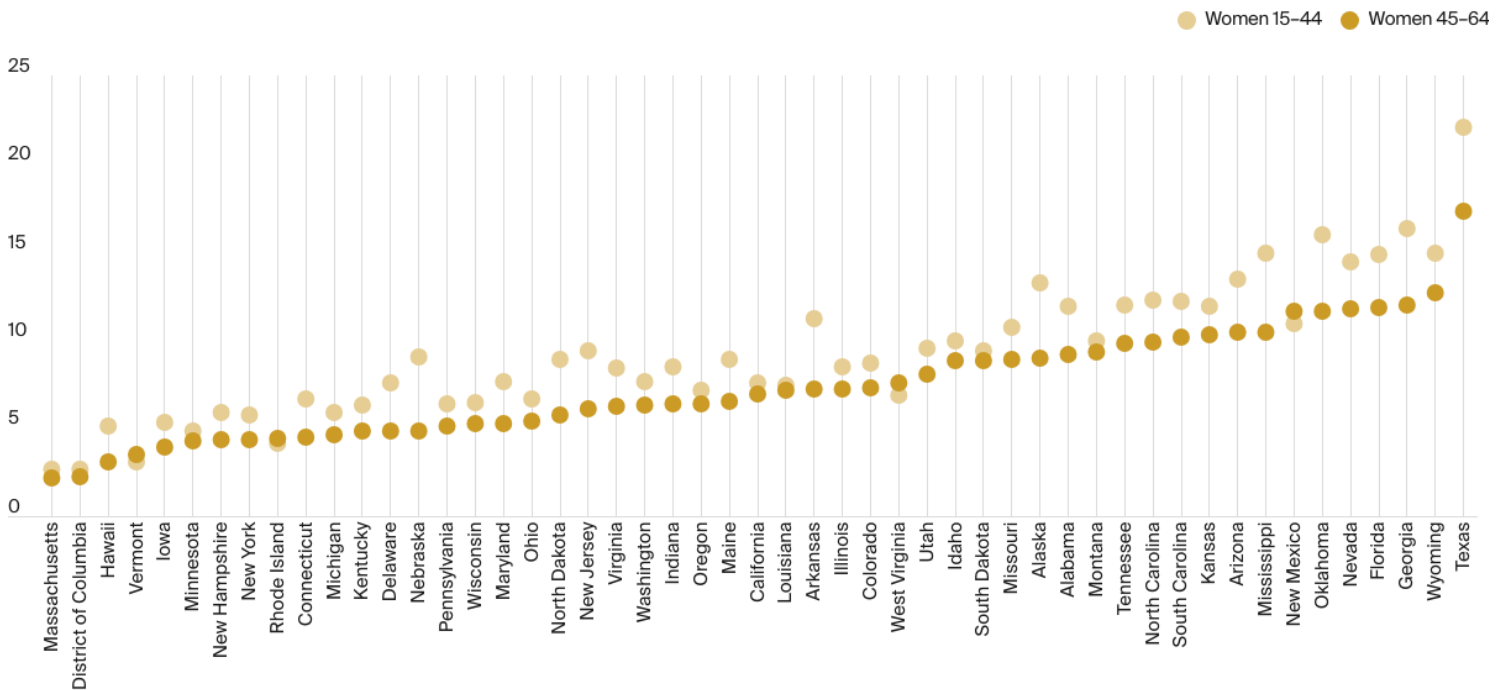
Before the ACA became law, younger adults were uninsured at much higher rates than older working-age adults because they were less likely to have coverage through a job. The ACA provided new coverage options and protections for younger people. These include: the option to stay on a parent's plan up to age 26; subsidized coverage through the marketplaces or Medicaid; bans on charging women of reproductive age higher premiums than men in the same age group; and requirements to cover services that women in this age group might need, including pregnancy care and contraception.

While the coverage age gap has narrowed since 2010, younger adults continue to be uninsured at higher rates than older working-age adults.⁴⁷ Among women, that gap persisted in most states in 2022. Women of reproductive age were uninsured at higher rates than women ages 45 to 64. Uninsured rates for women of reproductive age ranged from a low of 2.6 percent in Massachusetts to a high of 22 percent in Texas.

Persistent gaps reflect the lack of Medicaid expansion in 10 states; barriers to enrollment in Medicaid and the marketplaces for undocumented immigrants; and barriers for those eligible for coverage such as cost, lack of awareness, and periodic disenrollment from Medicaid due to fluctuations in income and other eligibility criteria.

Women ages 15 to 44 have slightly higher uninsured rates than women ages 45 to 64.

Percent uninsured



Download data

Note: States are sorted by the uninsured rate among women ages 45–64.

Data: American Community Survey, Public Use Microdata Sample (PUMS), 2022.

Source: Sara R. Collins et al., 2024 State Scorecard on Women's Health and Reproductive Care (Commonwealth Fund, July 2024). <https://doi.org/10.26099/6gr0-t974>

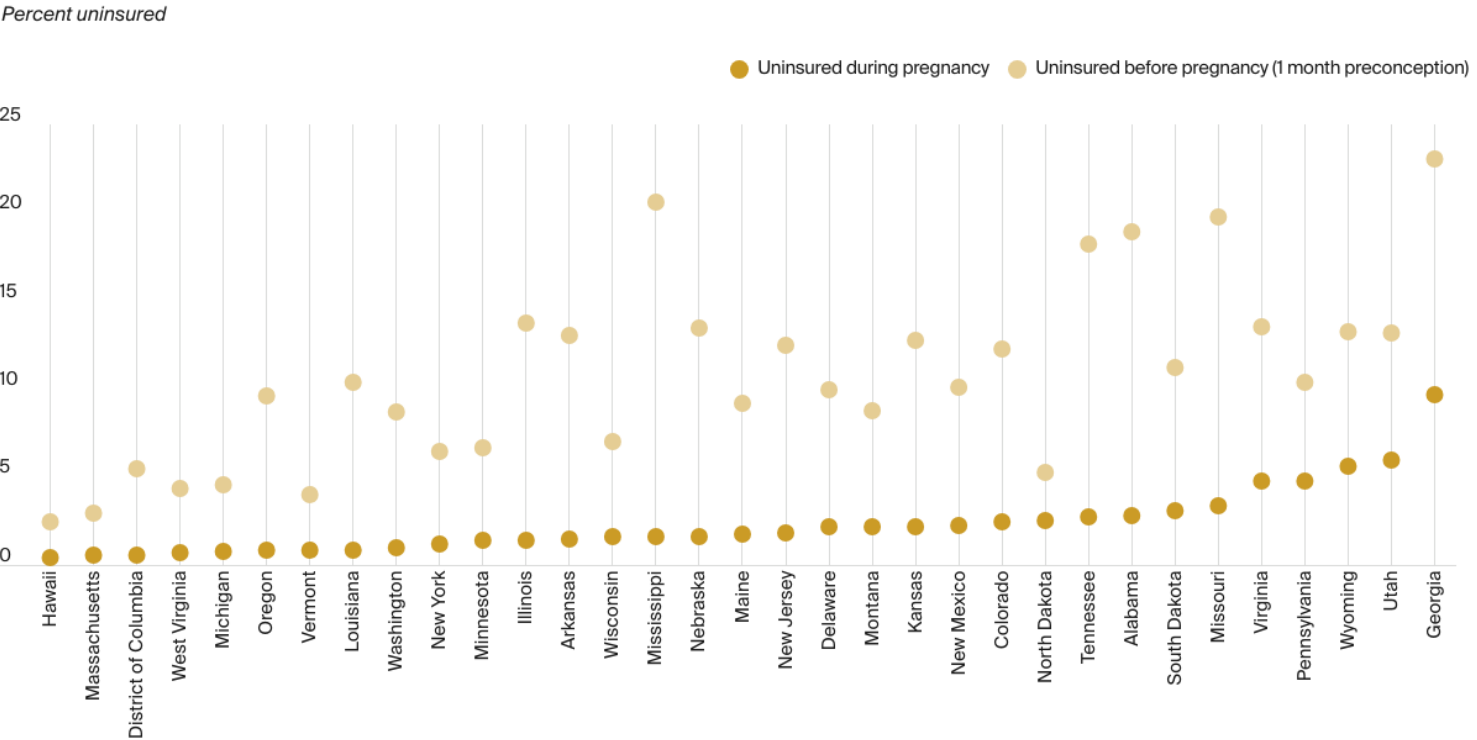
Federal law requires all state Medicaid programs to provide pregnancy-related coverage up to 138 percent of the federal poverty level. Most make the income threshold higher, with 32 states setting it at 200 percent of poverty or above.⁴⁸

Additionally, states cannot impose cost sharing for pregnancy-related services in Medicaid, and they must cover women for 60 days postpartum, with the option to extend the postpartum period to 12 months. Forty-seven states have implemented the 12-month extension, and three states are either planning to or are seeking approval. Delaware and Tennessee recently received federal approval to provide diapers for Medicaid-insured newborns.⁴⁹

Because of these federal requirements and state options, Medicaid is a critical source of insurance for pregnant women, covering 42 percent of births in the U.S. It's a particularly important source for Black people and AIAN people, covering two-thirds of their births. Consequently, in most states, uninsured rates for pregnant women are considerably lower

than they are for women prior to conception. This gap is particularly wide in states that haven't expanded their Medicaid programs, including Alabama, Georgia, Mississippi, and Tennessee.

Women giving birth are more likely to have health insurance coverage during pregnancy than before.



Download data

Note: Preconception refers to 1 month before pregnancy. Data not available in all states.

Data: [Pregnancy Risk Assessment Monitoring System \(PRAMS\) automated research file](#), 2021.

Source: Sara R. Collins et al., 2024 State Scorecard on Women's Health and Reproductive Care (Commonwealth Fund, July 2024). <https://doi.org/10.26099/6gr0-t974>

Insurance coverage is essential for timely health care. In states with the highest uninsured rates, including Texas, women of reproductive age report skipping care because of costs at much higher rates than in states like Hawaii, where most women in this age group have coverage.

Women living in states that have not expanded Medicaid eligibility report skipping care because of costs at higher rates than those in states that have expanded. Of the 10 states with the highest rates of access problems, seven had not expanded Medicaid by January 2022; Oklahoma did so only recently, in 2021.

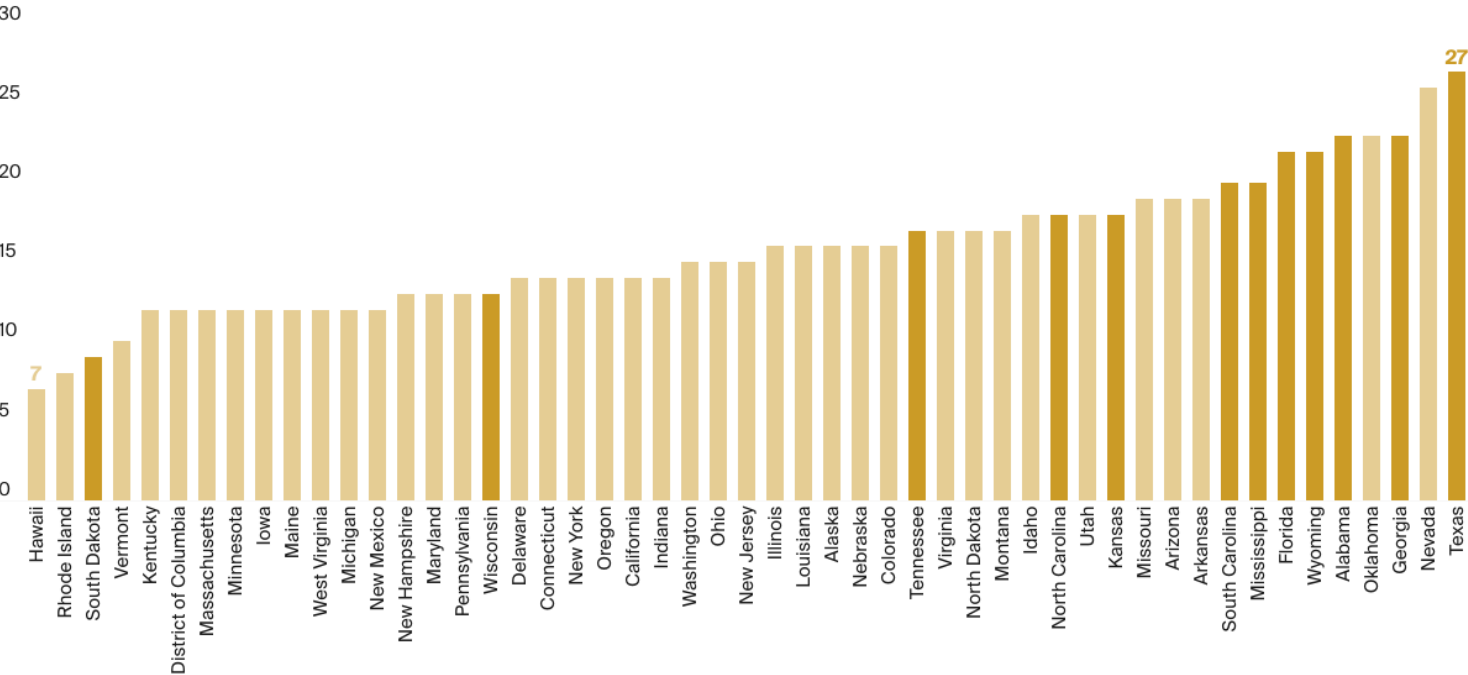
Immigration status can also undermine access to care. For example, Nevada, which has expanded its Medicaid program, has the highest number of undocumented immigrants, as a share of population, of any state.⁵⁰ Undocumented immigrants there are ineligible for Medicaid or subsidized health plans through the marketplaces; they can only get insurance through an employer or by purchasing a plan outside the marketplace, which is prohibitively expensive for most people.

A few states, including California, Colorado, Oregon, and Washington, have used state funds to expand access to health insurance for undocumented immigrants through Medicaid or the marketplaces.⁵¹ The Biden administration recently announced that it would allow young adult “Dreamers” — people who came to the United States as children and are protected against deportation by the Deferred Action for Childhood Arrivals (DACA) program — to gain coverage through the marketplaces starting in November 2024.⁵²

Finally, it's important to note that while insurance is necessary for accessing care, it must also provide good-quality coverage. Thirty percent of women ages 19 to 44 are underinsured, meaning they have high out-of-pocket costs or deductibles relative to their income.⁵³ In this age group, women are underinsured at higher rates than men. Being underinsured, along with having a poor-quality provider network, paying off medical debt, and other factors, can leave even women with coverage unable to afford health care.⁵⁴

In states that have not expanded Medicaid, women of reproductive age are more likely to skip needed care because of cost.

Percent of women ages 18–44 who went without care because of cost



Download data

Note: States in darker shade had not expanded Medicaid before January 1, 2022.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2022; and “Status of Medicaid Expansion,” Commonwealth Fund, last updated June 20, 2023.

Source: Sara R. Collins et al., 2024 State Scorecard on Women’s Health and Reproductive Care (Commonwealth Fund, July 2024). <https://doi.org/10.26099/6gr0-1974>

LESSONS FROM THE TOP STATES

Covering Women of Reproductive Age

Top 3 States



Women’s insurance coverage is directly related to state policy choices. States where uninsured rates for women of reproductive age are lowest have fully implemented the Affordable Care Act, including its Medicaid eligibility expansion. Massachusetts also implemented health insurance reforms prior to the ACA.

All state Medicaid programs must cover women earning less than 138 percent of poverty during pregnancy, and they have the option to increase income eligibility. Pregnant women earning more than 300 percent of the federal poverty level (\$45,000 for an individual and \$93,600 for a family of four) in the District of Columbia, Iowa, Missouri, West Virginia, and Wisconsin are eligible for Medicaid.⁵⁵ West Virginia had the fourth-lowest uninsured rate for women during pregnancy. Nearly all states have taken the new option to extend Medicaid coverage to 12 months postpartum.

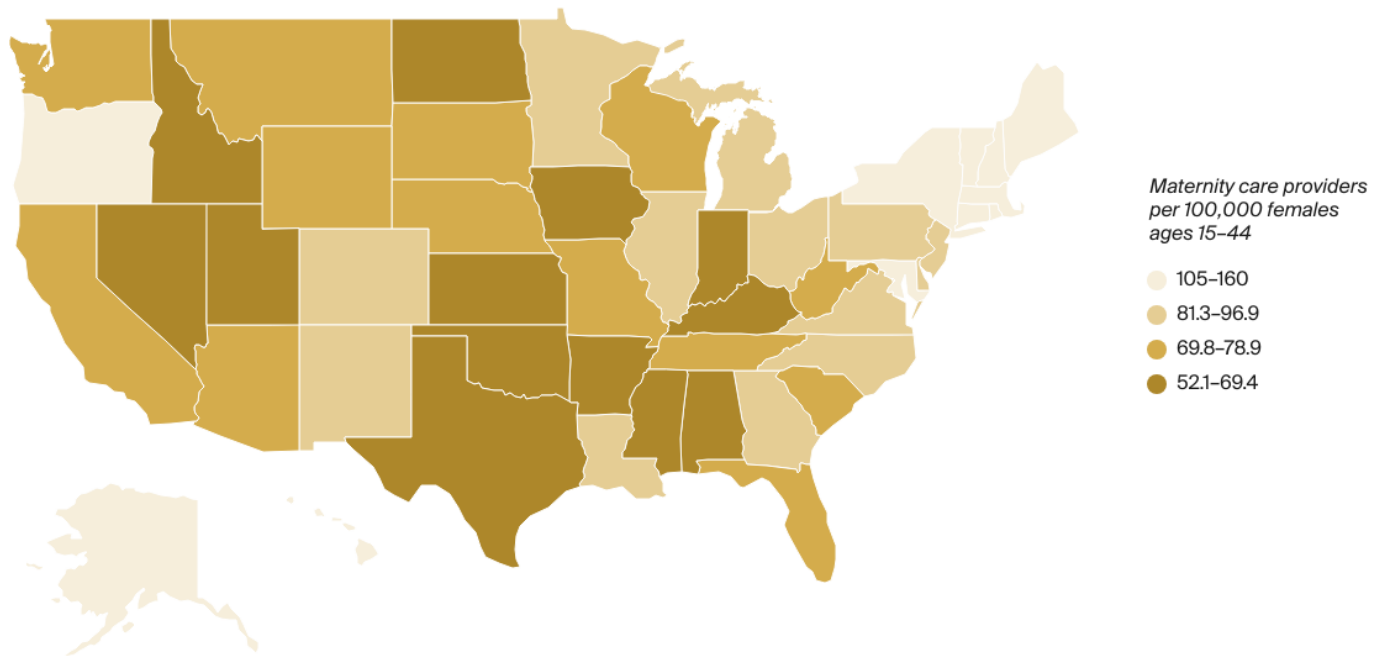
Having health insurance also doesn't guarantee access to care if people don't have ready access to providers. In 2023, 36 percent of U.S. counties were maternity care "deserts," meaning they lacked a hospital or birthing center providing obstetric care and they had no obstetric providers.⁵⁶ Limited access to providers means that people will struggle to access obstetric care and face barriers to getting the full continuum of prenatal and postnatal care.⁵⁷ States where a large share of residents live in rural areas also tend to have the fewest obstetric providers.

Many experts are concerned that abortion bans or limits may inadvertently reduce the number of providers offering maternity care, owing to increased risk of legal action that practices face. The following states now ban abortion in nearly all circumstances or impose gestational limits:⁵⁸

- There are abortion bans in Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia.
- There are gestational limits of six weeks in Florida, Georgia, and South Carolina; 12 weeks in Nebraska and North Carolina; and 15 to 18 weeks in Arizona and Utah.
- Courts in Montana and Wyoming have temporarily blocked those states' abortion bans, leaving in place their viability limits. The Iowa Supreme Court has ruled that the state's six-week gestational limit can soon be enforced as lawsuits against it proceed.

Of these 24 states, 21 have the fewest number of maternity care providers relative to the number of women who might need them. In 2023 and 2024, fewer medical school graduates applied to residency programs in states that banned abortion, both in obstetrics and gynecology and across all specialties, compared to states without bans.⁵⁹ This is an ominous development for these states, where providers are already scarce.

States with abortion restrictions tend to have the fewest number of maternity care providers.



[Download data](#)

Notes: Maternity care workforce includes M.D. + D.O. (obstetrics and gynecology), nurse midwives, and certified nurse midwives. As of July 3, 2024, there are abortion bans in Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia. There are gestational limits of six weeks in Florida, Georgia, and South Carolina; 12 weeks in Nebraska and North Carolina; and 15 to 18 weeks in Arizona and Utah.

Data: Area Health Resource File, 2022-2023; and "[Tracking Abortion Bans Across the Country](#)," *New York Times*, accessed July 3, 2024.

Source: Sara R. Collins et al., *2024 State Scorecard on Women's Health and Reproductive Care* (Commonwealth Fund, July 2024). <https://doi.org/10.26099/6gr0-t974>

Women's Health Is In a Perilous Place

Women of reproductive age have unique health care needs that have long left them vulnerable to health industry profit motives and discrimination, and political and judicial decisions that create barriers to their ability to access timely health care. Over the past 15 years, however, there has been a push to remove some of those barriers. For example:

- The ACA banned insurers in the individual market from charging young women higher premiums than young men and required them to cover maternity care, which they had rarely done prior to the law.⁶⁰
- The law required all private and public insurers, as well as employers, to cover contraception, with workarounds for religious objections subsequently added.
- The ACA expanded Medicaid eligibility and provided subsidies for marketplace coverage, reforms that halved the uninsured rate among women ages 19 to 64, from

18.5 percent to 9.7 percent, helping 8.4 million women gain coverage by 2022.⁶¹

- The Inflation Reduction Act of 2022 gave states the option of extending postpartum coverage to a full year. Prior to the ACA, pregnant women with incomes under 133 percent of poverty were made eligible for Medicaid up to 60 days postpartum. With more than half of pregnancy-related deaths occurring up to a year postpartum, nearly all state Medicaid programs have adopted this extension of coverage.⁶²
- The federal government and several states have implemented policies to reduce maternal mortality, including supporting state perinatal quality collaboratives and maternal mortality review committees.⁶³ Quality collaboratives are state or multistate networks of pediatricians, obstetricians, and midwives that are identifying weaknesses in perinatal care in their states and creating new approaches. Forty-nine states and the District of Columbia, New York City, and Philadelphia have formal maternal mortality review committees or legal requirements to review pregnancy-related deaths.⁶⁴
- In many states, efforts are underway to improve access to mental health care, substance use treatment, and preventive actions to control the upswing in syphilis cases.⁶⁵

But for women in many parts of the U.S., state variation in the implementation of federal law, along with recent court decisions, have erected obstacles to health care. Ongoing judicial action at the federal level, along with the potential for a policy reversal under the next administration, raise further concerns over the future of women's health. For example:

- Ten states have yet to expand Medicaid, leaving nearly 800,000 poor women uninsured. While one or two smaller southern states may move forward in the next few years, expansion in the populous states of Florida and Texas continues to face political headwinds. A federal policy solution is needed to correct this major ongoing gap in insurance coverage for poor people, who are disproportionately Black and Hispanic.
- The future of women's access to the full spectrum of reproductive health care is bleak in the nearly half of states where abortion access is either banned or significantly restricted.
- Women's ability to prevent pregnancy using contraception, or to become pregnant using IVF, is under threat. Two landmark Supreme Court decisions in the 1960s and 1970s granted Americans a constitutional right to contraception.⁶⁶ But widespread

misunderstanding and misinformation about reproduction and contraception could limit people's access to contraceptives or interfere with widely used methods of getting pregnant.

- The outcome of the 2024 presidential election also may be a factor in women's future access to reproductive health care. While the Biden administration has promulgated regulations and guidance in the wake of the *Dobbs* decision aimed at safeguarding women's health and privacy, a Trump presidency may seek to undo those protections.⁶⁷

The *State Scorecard on Women's Health and Reproductive Care* provides evidence of stark regional and racial and ethnic divides in state health system performance on women's health care. The current and future policy environment could make those divides deeper still and weaken performance in even more states. Our findings suggest that urgent action by Congress and state policymakers is necessary to ensure women have timely access to complete health and reproductive care, regardless of who they are, what they earn, or where they live.

2024 Summary of State Rankings on Women's

Click on the headers to sort rankings by domain.

Source: Sara R. Collins et al., *2024 State Scorecard on Women's Health and Reproductive Care* (Commonwealth Fund)
<https://doi.org/10.26099/6gr0-t974>

SCORECARD METHODS

The Commonwealth Fund's *2024 State Scorecard on Women's Health and Reproductive Care* evaluates states on 32 measures grouped into three dimensions. The report generally reflects data from 2021 and 2022.

Health Outcomes (12 indicators): includes indicators of all-cause, maternal, and infant mortality, breast and cervical cancer deaths, preterm births, mental health conditions, syphilis infections, and intimate partner violence.

Coverage, Access, and Affordability (8 indicators): includes rates of uninsurance for women, indicators of forgone care due to cost, usual source of care, maternity care workforce, and abortion access.

Health Care Quality and Prevention (12 indicators): includes measures of receipt of preventive care (flu shot, breast and cervical cancer screenings, postpartum depression screening, dental cleaning), and some measures of quality such as prenatal care and low-risk cesarean births.

The development of this new scorecard was made possible through collaboration with Brittni Frederiksen, KFF; Danielle Gartner, Michigan State University; Zsakeba Henderson, National Institute for Children's Health Quality; Anne Markus, George Washington University; and Kara Zivin, University of Michigan.

Guiding Principles

The following principles guided the development of the scorecard report:

Performance Metrics. The 32 metrics selected for this report span health care system performance, representing important dimensions and measurable aspects of care delivery and population health. Where possible, indicators align with those used in previous scorecards.

Data Sources. Indicators generally draw from publicly available data sources, including government-sponsored surveys, registries, publicly reported quality indicators, vital statistics and mortality data. Data on abortion clinics was obtained upon request from the Advancing New Standards in Reproductive Health (ANSIRH) Abortion Facility Database at the University of California, San Francisco. The most current data available were used in this report whenever possible. Appendix A1 provides detail on the data sources and time frames.

Scoring and Ranking Methodology. For each indicator, a state's standardized z-score is calculated by subtracting the 51-state average (including the District of Columbia as if it were a state) from the state's observed rate, and then dividing by the standard deviation of all observed state rates. States' standardized z-scores are averaged across all indicators within the performance dimension, and dimension scores are averaged into an overall score. Ranks are assigned based on the overall score. This approach gives each dimension equal weight and, within each dimension, it weights all indicators equally. This method accommodates the different scales used across the scorecard indicators (for example, percentages and population-based rates).

Regional Comparisons

The scorecard groups states into the eight regions used by the Bureau of Economic Analysis to measure and compare economic activity. The regions are:

Great Lakes Illinois, Indiana, Michigan, Ohio, Wisconsin

Mid-Atlantic Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania

New England Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Plains Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota

Rocky Mountain Colorado, Idaho, Montana, Utah, Wyoming

Southeast Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia

Southwest Arizona, New Mexico, Oklahoma, Texas

West Alaska, California, Hawaii, Nevada, Oregon, Washington

ACKNOWLEDGMENTS

We owe our sincere appreciation to the five members of our advisory panel who helped us identify measures: Brittni Frederiksen, KFF; Danielle Gartner, Michigan State University; Zsakeba Henderson, National Institute for Children's Health Quality; Anne Markus, George Washington University; and Kara Zivin, University of Michigan.

We also would like to thank the researchers who provided data and/or analytic support: Rosalyn Schroeder from the Advancing New Standards in Reproductive Health (ANSIRH) Abortion Facility Database Committee at the University of California, San Francisco, and Kate Lonborg, Caitlin Burbank, and Gulcan Cil from the Center for Evidence-Based Policy at Oregon Health and Science University.

We would like to thank the following Commonwealth Fund staff members: Joseph Betancourt, Melinda Abrams, Rachel Nuzum, for providing constructive feedback and guidance; Kristen Kolb for research assistance; and the Fund's communications and support teams, including Aishu Balaji, Chris Hollander, Bethanne Fox, Barry Scholl, Josh Tallman,

Jen Wilson, Paul Frame, Sam Chase, Alexandra Bryan, Paige Huffman, Avni Gupta, Evan Gumas, Munira Gunja, and Sara Federman for their guidance, editorial and production support, and public dissemination efforts.

Finally, we wish to acknowledge Maya Brod of Burness Communications for her assistance with media outreach, and the Center for Evidence-Based Policy at Oregon Health and Science University for its support of the research unit, which enabled the analysis and development of the scorecard report.

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PUBLICATION DETAILS

DATE

July 18, 2024

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CITATION

Sara R. Collins et al., *2024 State Scorecard on Women's Health and Reproductive Care* (Commonwealth Fund, July 2024).
<https://doi.org/10.26099/6gr0-t974>

AREA OF FOCUS

Improving Health Care Quality

TOPICS

**Women's Health,
Maternal Health,
Health Disparities,
Health Outcomes,
Coverage and Access,
Quality of Care,
Affordability,
State Health Policy,
Medicaid Expansion**