

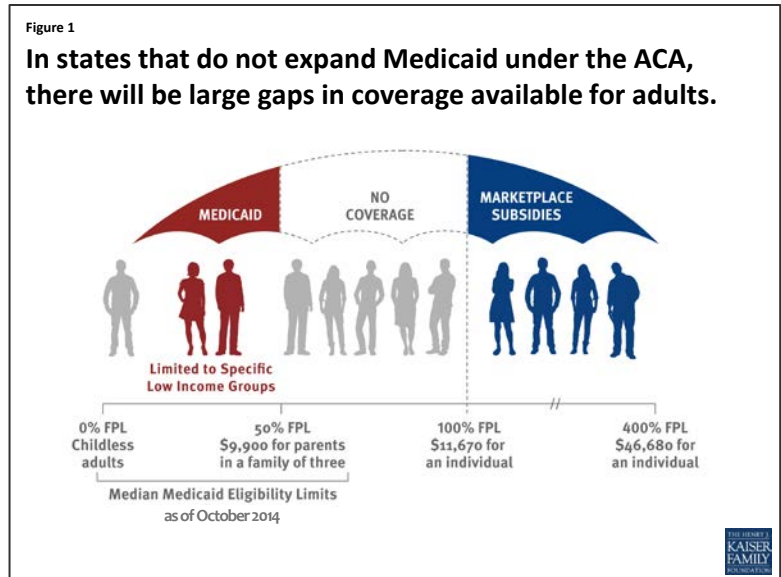
November 2014 | Issue Brief

The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update

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One of the major coverage provisions of the 2010 Affordable Care Act (ACA) is the expansion of Medicaid eligibility to nearly all low-income individuals with incomes at or below 138 percent of poverty (\$27,310 for a family of three¹). This expansion fills in historical gaps in Medicaid eligibility for adults and was envisioned as the vehicle for extending insurance coverage to low-income individuals, with premium tax credits for Marketplace coverage serving as the vehicle for covering people with moderate incomes. While the Medicaid expansion was intended to be national, the June 2012 Supreme Court ruling essentially made it optional for states.

As of October 2014, 23 states were not expanding their programs. Medicaid eligibility for adults in states not expanding their programs is quite limited: the median income limit for parents in 2014 is just 50% of poverty, or an annual income of \$9,893 a year for a family of three, and in nearly all states not expanding, childless adults will remain ineligible.² Further, because the ACA envisioned low-income people receiving coverage through Medicaid, it does not provide financial assistance to people below poverty for other coverage options. As a result, in states that do not expand Medicaid, many adults will fall into a “coverage gap” of having incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits (Figure 1).



This brief presents estimates of the number of people who fall into the coverage gap, describes who they are, and discusses the implications of them being left out of ACA coverage expansions. An overview of the methodology underlying the analysis can be found in the Methods box at the end of the report, and more detail is available in the Technical Appendices available [here](#), [here](#), and [here](#).

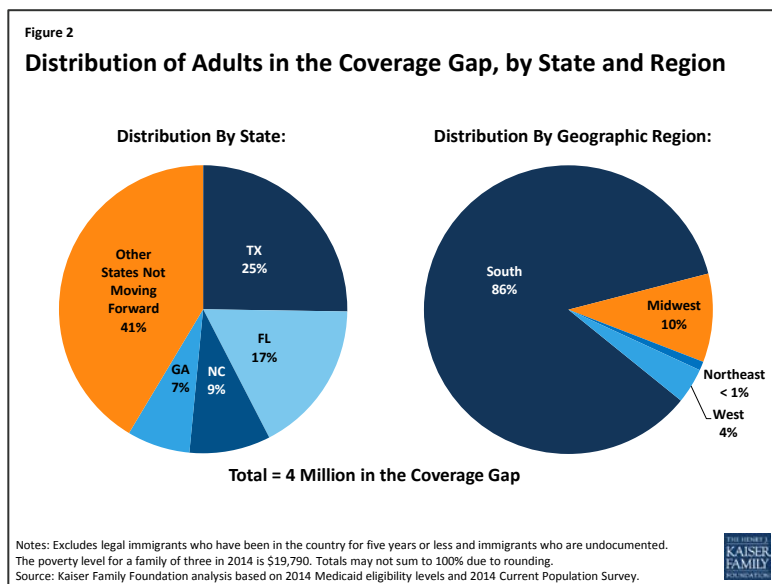
How Many People Are in the Coverage Gap?

Nationally, nearly four million poor uninsured adults fall into the “coverage gap” that results from state decisions not to expand Medicaid, meaning their income is above current Medicaid eligibility but below the lower limit for Marketplace premium tax credits. These individuals would have been newly-eligible for Medicaid had their state chosen to expand coverage.

In the past year, the number of people falling into the coverage gap has declined as more states have taken up the Medicaid expansion. Since September 30, 2013, three states (Ohio, New Hampshire, and Pennsylvania) have opted to expand their Medicaid programs, extending ACA-related assistance to approximately 600,000 uninsured nonelderly adults.

Adults left in the coverage gap due to current state decisions not to expand Medicaid are spread across the states not expanding their Medicaid programs but are concentrated in states with the largest uninsured populations (Table 1). A quarter of people in the coverage gap reside in Texas, which has both a large uninsured population and very limited Medicaid eligibility (Figure 2). Seventeen percent live in Florida, nine percent North Carolina, and seven percent in Georgia. There are no uninsured adults in the coverage gap in Wisconsin because the state is providing Medicaid eligibility to adults up to the poverty level.

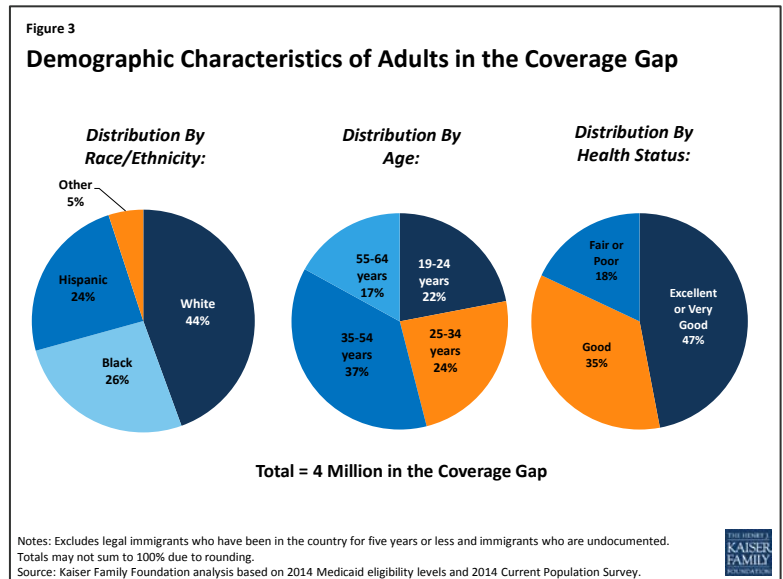
The geographic distribution of the population in the coverage gap reflects both population distribution and regional variation in state take-up of the ACA Medicaid expansion. As a whole, more people—and in particular more poor uninsured adults—reside in the South than in other regions.³ Further, the South has higher uninsured rates and more limited Medicaid eligibility than other regions. Southern states also have disproportionately opted not to expand their programs, and nearly half (11 out of 23) of the states not expanding Medicaid are in the South. These factors combined mean 86% of people in the coverage gap reside in the South (Figure 2).



What Are Characteristics of People in the Coverage Gap?

The characteristics of the population that falls into the coverage gap largely mirror those of poor uninsured adults. For example, because racial/ethnic minorities are more likely than White non-Hispanics to lack insurance coverage and are more likely to live in families with low incomes, they are disproportionately represented among poor uninsured adults and among people in the coverage gap. Nationally, 44% of uninsured adults in the coverage gap are White non-Hispanics, 24% are Hispanic, and 26% are Black (Figure 3). However, the race and ethnicity of people in the coverage gap also reflects differences in the racial/ethnic composition between states moving forward with the Medicaid expansion and states not planning to expand.

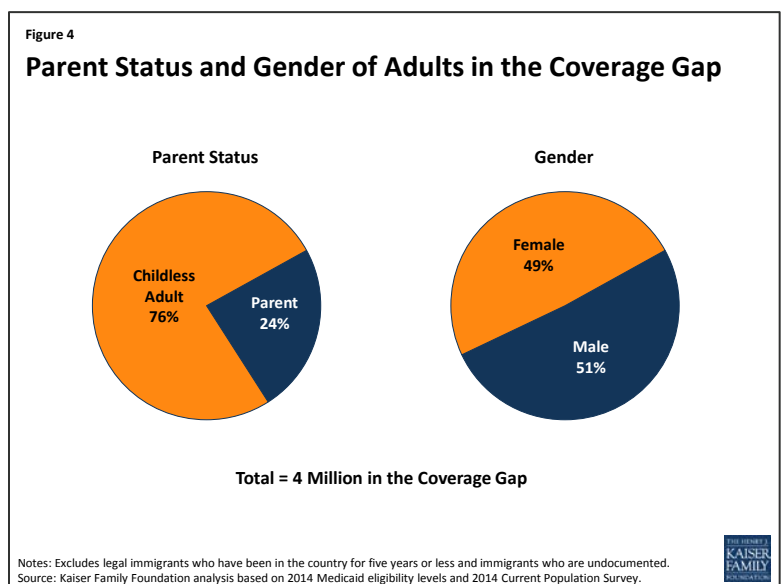
Several states that have large Hispanic populations (e.g., California, New York, and Arizona) are moving forward with the expansion, while other states with large Black populations (e.g., Florida, Georgia, and Texas) are not. As a result, Blacks account for a slightly higher share of people in the coverage gap compared to the total poor adult uninsured population, while Hispanics account for a slightly lower share. The racial/ethnic characteristics of the population in the coverage gap vary widely by state, mirroring the underlying characteristics of the state population.



Nonelderly adults of all ages fall into the coverage gap (Figure 3). Notably, over half are middle-aged (age 35 to 54) or near elderly (age 55 to 64). Adults of these ages are likely to have increasing health needs, and research has demonstrated that uninsured people in this age range may leave health needs untreated until they become eligible for Medicare at age 65.⁴

While nearly half of people in the coverage gap report that their health is excellent or very good, nearly a fifth (18%) report that they are in fair or poor health (Figure 3). These individuals have known health problems that likely require medical attention. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.⁵ When they do seek care, the uninsured often face unaffordable medical bills.⁶

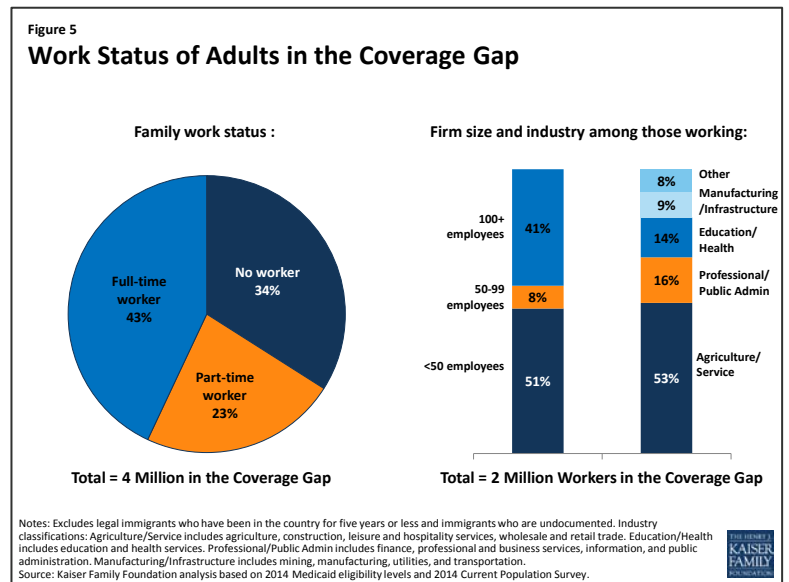
The characteristics of people in the coverage gap also reflect Medicaid program rules in states not expanding their programs. Because non-disabled adults without dependent children are ineligible for Medicaid coverage in most states not expanding Medicaid, regardless of their income, adults without dependent children account for a disproportionate share of people in the coverage gap (76%) (Figure 4). Still, nearly a quarter (24%) of people in the coverage gap are poor parents whose income places them above Medicaid eligibility levels. The share of people in the coverage gap who are parents with dependent children varies by state (see Table 1) due to variation in current state eligibility. For example, Alaska, Maine, and Tennessee will cover parents up to at least poverty as of 2014, so all people in the coverage gap in those states are adults without dependent children.



Women account for just under half (49%) of adults in the coverage gap (Figure 4). Women actually make up the majority of poor uninsured adults in states not expanding their program but are more likely than men to qualify for Medicaid under current rules. As a result, the gender split actually indicates a disproportionate share of men falling into the coverage gap. Of poor adults in non-expansion states who would have been eligible for Medicaid had their state expanded, 86 percent of males land in the gap, compared to 78 percent of females (data not shown). This disproportionate gender pattern occurs because men are much less likely than women to meet current Medicaid eligibility in states not expanding their programs.

The work status of people in the coverage gap indicates that there are limited coverage options available for people in this situation. Two-thirds (66%) of people in the coverage gap are in a family with a worker, and 54% are working themselves (Figure 5). While workers could potentially have an offer of coverage through their employer, the majority of workers in the coverage gap (51%) work for small firms (<50 employees) that will not be subject to ACA penalties for not offering coverage. Further, many firms do not offer coverage to part-time workers. A majority of workers in the coverage gap also work in industries with historically low insurance rates, such as the agriculture and service industries.

More than a third (34%) of adults in the coverage gap are in a family with no workers. Since the Medicaid expansion was designed to reach those left out of the employer-based system, and because people in the coverage gap by definition are poor, it is not surprising that most are unlikely to have access to health coverage through a job.



Conclusion

The ACA Medicaid expansion was designed to address the high uninsured rates among adults living below poverty, providing a coverage option for people who had limited access to employer coverage and limited income to purchase coverage on their own. However, with many states opting not to implement the Medicaid expansion, millions of adults will remain outside the reach of the ACA and continue to have limited, if any, options for health coverage: they are ineligible for publicly-financed coverage in their state, most do not have access to employer-based coverage through a job, and all have limited income available to purchase coverage on their own.

The majority of people in the coverage gap are working poor—that is, employed either part-time or full-time but still living below the poverty line. Given the characteristics of their employment, it is likely that many will continue to lack access to coverage through their job even after the ACA provisions for employer responsibility for coverage are effective in 2015.⁷ Further, even if they do receive an offer from their employer that meets ACA requirements, many will find their share of the cost to be unaffordable. Because this population is generally

exempt from the individual mandate, and because firms will not face a penalty for these workers remaining uninsured, they will continue to fall between the cracks in the employer-based system.

It is unlikely that people who fall into the coverage gap will be able to afford ACA coverage without financial assistance: in 2014, the national average premium for a 40-year-old individual purchasing coverage through the Marketplace was \$270 per month for a silver plan and \$224 per month for a bronze plan,⁸ which equates to about half of income for those at the lower income range of people in the gap and about a quarter of income for those at the higher income range of people in the gap. Further, people in the coverage gap are ineligible for cost-sharing subsidies for Marketplace plans and could face additional out-of-pocket costs up to \$6,350 a year if they were to purchase Marketplace coverage. Given the limited budgets of people in the coverage gap, these costs are likely prohibitively expensive. Thus, it is most likely that adults in the coverage gap will remain uninsured, even after the ACA is fully implemented.

If they remain uninsured, adults in the coverage gap are likely to face barriers to needed health services or, if they do require medical care, potentially serious financial consequences. Many are in fair or poor health or are in the age range when health problems start to arise, but lack of coverage may lead them to postpone needed care due to the cost. While the safety net of clinics and hospitals that has traditionally served the uninsured population will continue to be an important source of care for the remaining uninsured under the ACA, this system has been stretched in recent years due to increasing demand and limited resources.

Further, the racial and ethnic composition of the population that falls into the coverage gap indicates that state decisions not to expand their programs disproportionately affect people of color, particularly Black Americans. This disproportionate effect occurs because the racial and ethnic composition of states not expanding their Medicaid programs differs from the ones that are expanding. As a result, state decisions about whether to expand Medicaid have implications for efforts to address disparities in health coverage, access, and outcomes among people of color.

Last, the population in the coverage gap shows that, as a result of state decisions not to expand their Medicaid programs, many remaining uninsured under the ACA will reflect the legacy of the system linking Medicaid coverage to only certain categories of people. Many people who fall outside these categories—specifically men and adults without dependent children—still have a need for health coverage. The ACA Medicaid expansion was designed to end categorical eligibility for Medicaid, but in states not implementing the expansion, the vestiges of categorical eligibility will remain.

Table 1: Number and Characteristics of Poor Uninsured Nonelderly Adults in the ACA Coverage Gap, by State

State	Number in Coverage Gap	Share in Coverage Gap who Are:		
		Adults without Dependent Children	Female	In a Working Family
All states not expanding Medicaid*	3,846,000	76%	49%	66%
Alabama	176,000	70%	52%	63%
Alaska	10,500	100%	NA	NA
Florida	669,000	79%	50%	64%
Georgia	282,000	76%	52%	57%
Idaho	51,000	81%	50%	72%
Indiana	138,000	67%	50%	66%
Kansas	60,000	83%	33%	78%
Louisiana	166,000	82%	46%	68%
Maine	22,000	100%	NA	53%
Mississippi	107,000	90%	48%	67%
Missouri	147,000	63%	55%	67%
Montana	35,000	82%	NA	67%
Nebraska	31,000	86%	50%	80%
North Carolina	357,000	75%	47%	62%
Oklahoma	104,000	88%	50%	58%
South Carolina	178,000	83%	49%	48%
South Dakota	NA	NA	NA	NA
Tennessee	142,000	100%	NA	NA
Texas	948,000	68%	51%	76%
Utah	30,000	75%	NA	NA
Virginia	171,000	79%	44%	70%
Wyoming	14,000	69%	58%	78%

NOTES: Excludes undocumented immigrants and legal immigrants who have been in the US for <5 years.

* Wisconsin is not included in Table 1 because the state is providing Medicaid eligibility to adults up to the poverty level under a Medicaid waiver. As a result, there is no one in the coverage gap in Wisconsin.

NA: Sample size too small for reliable estimate.

SOURCES: KFF analysis of March 2014 CPS and Medicaid MAGI eligibility levels.

Methods

This analysis uses data from the 2014 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). The CPS ASEC provides socioeconomic and demographic information for the United States population and specific subpopulations. Importantly, the CPS ASEC provides detailed data on families and households, which we use to determine income for ACA eligibility purposes (see below for more detail). Notably, with the 2014 ASEC, Census implemented a fundamental redesign of the health insurance coverage questions. This redesign aimed both to address longstanding issues with measurement of insurance coverage in the ASEC and to capture new coverage categories available under the ACA. The redesigned insurance questions lead to a lower estimate of the uninsured rate compared to the previous approach, addressing a longstanding issue of under-reporting of coverage in the ASEC. As a result of these changes, health coverage data for the 2014 release (reflecting coverage in calendar year 2013) are not comparable with estimates from previous years.

Medicaid and Marketplaces have different rules about household composition and income for eligibility. For this analysis, we calculate household membership and income for both Medicaid and Marketplace premium tax credits for each person individually, using the rules for each program. For more detail on how we construct Medicaid and Marketplace households and count income, see the detailed technical Appendix A available [here](#).

Undocumented immigrants are ineligible for Medicaid and Marketplace coverage. Since CPS data do not directly indicate whether an immigrant is lawfully present, we draw on the methods underlying the 2013 analysis by the State Health Access Data Assistance Center (SHADAC) and the recommendations made by Van Hook et. al.^{9,10} This approach uses the Survey of Income and Program Participation (SIPP) to develop a model that predicts immigration status; it then applies the model to CPS, controlling to state-level estimates of total undocumented population from Department of Homeland Security. For more detail on the immigration imputation used in this analysis, see the technical Appendix B available [here](#).

Individuals in tax-filing units with access to an affordable offer of Employer-Sponsored Insurance are still potentially MAGI-eligible for Medicaid coverage, but are ineligible for advance premium tax credits in the Health Insurance Exchanges. Since CPS data do not directly indicate whether workers have access to ESI, we draw on the methods comparable to our imputation of authorization status. For more detail on the offer imputation used in this analysis, see the technical Appendix C available [here](#). As of January 2014, Medicaid financial eligibility for most nonelderly adults is based on modified adjusted gross income (MAGI). To determine whether each individual is eligible for Medicaid, we use each state's MAGI eligibility level that was effective as of July 2014.¹¹ Some nonelderly adults with incomes above MAGI levels may be eligible for Medicaid through other pathways; however, we only assess eligibility through the MAGI pathway.¹²

An individual's income is likely to fluctuate throughout the year, impacting his or her eligibility for Medicaid. Our estimates are based on annual income and thus represent a snapshot of the number of people in the coverage gap at a given point in time. Over the course of the year, a larger number of people are likely to move and out of the coverage gap as their income fluctuates.

¹ The 2014 federal poverty guideline for a family of three was \$19,790. See: <http://aspe.hhs.gov/poverty/14poverty.cfm>.

² Of the states not moving forward with the expansion, only Wisconsin provides full Medicaid coverage to adults without dependent children as of 2014.

³ Stephens, J., S. Artiga, and J. Paradise. Health Coverage and Care in the South in 2014 and Beyond. (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured), April 2014, available at: <http://kff.org/report-section/health-coverage-and-care-in-the-south-in-2014-and-beyond-health-coverage-and-care-in-the-south-today/>

⁴ McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. "Use of Health Services by Previously Uninsured Medicare Beneficiaries." *New England Journal of Medicine*. 2007 July 12, 357(2): 143-53.

⁵ For a review of findings on access to care for the uninsured, see: Kaiser Commission on Medicaid and the Uninsured. *The Uninsured: A Primer- Key Facts About Health Insurance on the Eve of Coverage Expansions*. (Washington, DC: Kaiser Family Foundation),

October 23, 2013. Available at: <http://www.kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-on-the-eve-of-coverage-expansions/>.

⁶ Ibid.

⁷ See <http://www.kff.org/infographic/employer-responsibility-under-the-affordable-care-act/> for a review of these requirements.

⁸ The methods for arriving at this estimate can be found on the Kaiser Family Foundation Subsidy Calculator, (available here: <http://www.kff.org/interactive/subsidy-calculator/>). The calculator is based on Congressional Budget Office (CBO) projections from July 2012 (Available here: <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>)

⁹ State Health Access Data Assistance Center. 2013. "State Estimates of the Low-income Uninsured Not Eligible for the ACA Medicaid Expansion." Issue Brief #35. Minneapolis, MN: University of Minnesota. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404825.

¹⁰ Van Hook, J., Bachmeier, J., Coffman, D., and Harel, O. "Can We Spin Straw into Gold? An Evaluation of Immigrant Legal Status Imputation Approaches" *Demography*. Forthcoming.

¹¹ Kaiser Commission on Medicaid and the Uninsured. *Fact Sheet: Medicaid Eligibility for Adults as of January 1, 2014*. (Washington, DC: Kaiser Family Foundation), October 1, 2014. Available at: <http://www.kff.org/medicaid/fact-sheet/medicaid-eligibility-for-adults-as-of-january-1-2014/>.

¹² Non-MAGI pathways for nonelderly adults include disability-related pathways, such as SSI beneficiary; Qualified Severely Impaired Individuals; Working Disabled; and Medically Needy. We are unable to assess disability status in the CPS sufficiently to model eligibility under these pathways. However, previous research indicates high current participation rates among individuals with disabilities (largely due to the automatic link between SSI and Medicaid in most states, see Kenney GM, V Lynch, J Haley, and M Huntress. "Variation in Medicaid Eligibility and Participation among Adults: Implications for the Affordable Care Act." *Inquiry*. 49:231-53 (Fall 2012)), indicating that there may be a small number of eligible uninsured individuals in this group. Further, many of these pathways (with the exception of SSI, which automatically links an individual to Medicaid in most states) are optional for states, and eligibility in states not implementing the ACA expansion is limited. For example, the median income eligibility level for coverage through the Medically Needy pathway is 15% of poverty in states that are not expanding Medicaid, and most states not expanding Medicaid do not provide coverage above SSI levels for individuals with disabilities. (See: O'Mally-Watts, M and K Young. *The Medicaid Medically Needy Program: Spending and Enrollment Update*. (Washington, DC: Kaiser Family Foundation), December 2012. Available at: <http://www.kff.org/medicaid/issue-brief/the-medicaid-medically-needy-program-spending-and/>. And Kaiser Commission on Medicaid and the Uninsured, "Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities," February 2010. Available at: <http://www.kff.org/medicaid/issue-brief/medicaid-financial-eligibility-primary-pathways-for-the-elderly-and-people-with-disabilities/>.