

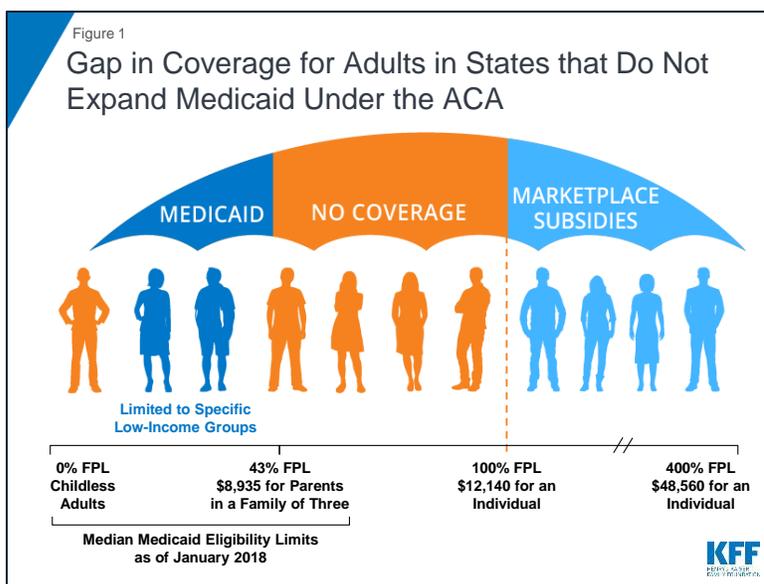
The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid

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While millions of people have gained coverage through the expansion of Medicaid under the Affordable Care Act (ACA), state decisions not to implement the expansion leave many without an affordable coverage option. Under the ACA, Medicaid eligibility is extended to nearly all low-income individuals with incomes at or below 138 percent of poverty (\$17,236 for an individual in 2019¹). 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 March 2019, 14 states had not expanded their programs.²

Medicaid eligibility for adults in states that did not expand their programs is quite limited: the median income limit for parents in these states is just 43% of poverty, or an annual income of \$8,935 for a family of three in 2018³, and in nearly all states not expanding, childless adults remain ineligible.⁴ 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, including all childless adults, fall into a “coverage gap” of having incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits (Figure 1).

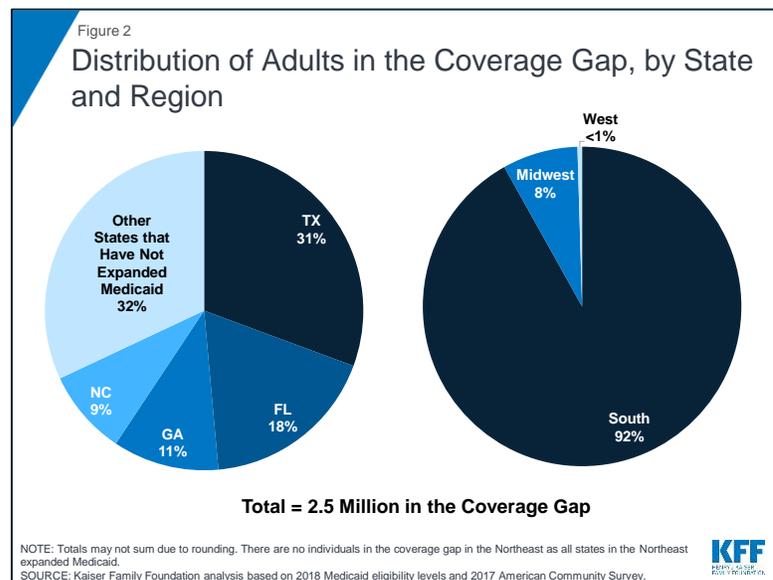


This brief presents estimates of the number of people in non-expansion states who could have been reached by Medicaid but instead fall into the coverage gap and discusses the implications of them being left out of ACA coverage expansions. An overview of the methodology underlying the analysis can be found in the [Data and Methods](#), and more detail is available in the [Technical Appendices](#).

How Many Uninsured People Who Could Have Been Eligible for Medicaid Are in the Coverage Gap?

Nationally, more than two million⁵ poor uninsured adults fall into the “coverage gap” that results from state decisions not to expand Medicaid (Table 1), meaning their income is above current Medicaid eligibility but below the lower limit for Marketplace premium tax credits. These individuals would be eligible for Medicaid had their state chosen to expand coverage. Reflecting limits on Medicaid eligibility outside ACA pathways, most people in the coverage gap (76%) are adults without dependent children.

Adults left in the coverage gap are spread across the states not expanding their Medicaid programs but are concentrated in states with the largest uninsured populations. Nearly a third of people in the coverage gap reside in Texas, which has both a large uninsured population and very limited Medicaid eligibility (Figure 2). Eighteen percent live in Florida, eleven percent in Georgia, and nine percent in North Carolina. 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 under a Medicaid waiver.



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. The South has relatively higher numbers of poor uninsured adults than in other regions, has higher uninsured rates and more limited Medicaid eligibility than other regions, and accounts for the majority (9 out of 14) of states that opted not to expand Medicaid.⁶ As a result, more than nine in ten people in the coverage gap reside in the South (Figure 2).

What Would Happen if All States Expanded Medicaid?

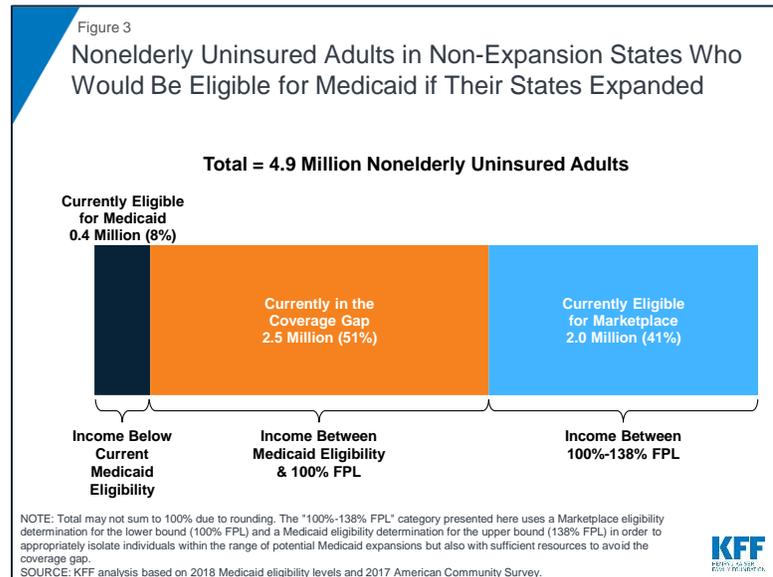
If states that are currently not expanding their programs adopt the Medicaid expansion, all of the 2.5 million adults in the coverage gap would gain Medicaid eligibility. In addition, 2.0 million uninsured adults who are currently eligible for Marketplace coverage (those with incomes between 100 and 138% of poverty⁷) would also gain Medicaid eligibility (Figure 3 and Table 1). Though most of these adults are eligible for tax credits to purchase Marketplace coverage,⁸ Medicaid coverage may provide lower

premiums or cost-sharing than they would face under Marketplace coverage. For example, research from early implementation of the ACA showed that coverage of behavioral health services, prescription drugs, rehabilitative and habilitative services, and long-term services and supports may be more limited in the Marketplace compared to Medicaid.^{9,10} In addition, research examining the population with incomes between 100-138% FPL in expansion and non-expansion states finds that Medicaid expansion coverage produced far greater reductions than subsidized Marketplace coverage in average total out-of-pocket spending, average out-of-pocket premium spending, and average cost-sharing spending.¹¹

A small number (about 409,000) of uninsured adults in non-expansion states are already eligible for Medicaid under eligibility pathways in place before the ACA. If all states expanded Medicaid, those in the coverage gap and those who are instead eligible for Marketplace coverage would bring the number of nonelderly uninsured adults eligible for Medicaid to nearly 4.9 million people in the fourteen current non-expansion states. The potential scope of Medicaid varies by state (Table 1).

Discussion

The ACA Medicaid expansion was designed to address the high uninsured rates among low-income adults, providing a coverage option for people with limited access to employer coverage and limited income to purchase coverage on their own. In states that expanded Medicaid, millions of people gained coverage, and the uninsured rate dropped significantly as a result of the expansion.¹² However, with many states opting not to implement the Medicaid expansion, millions of uninsured adults remain outside the reach of the ACA and continue to have limited options for affordable health coverage. From 2016 to 2017, non-expansion states saw a significant increase in their uninsured rate, while expansion states saw a decrease.¹³



By definition, people in the coverage gap have limited family income and live below the poverty level. They are likely in families employed in very low wage jobs, employed part-time, or with a fragile or unpredictable connection to the workforce. Given limited offer rates of employer-based coverage for employees with these work characteristics, it is likely that 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, as they are not eligible for premium subsidies: in 2019, the national average unsubsidized premium for a 40-year-old non-smoking individual purchasing coverage through the Marketplace was \$478 per month for the lowest-cost silver plan and \$340 per month for a bronze plan,¹⁴ which equates to nearly eighty percent of income for those at the lower income range of people in the gap and more than a third of income for those at the higher income range of people in the gap.

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.

Most people in the coverage gap live in the South, leading state decisions about Medicaid expansion to exacerbate geographic disparities in health coverage. In addition, because several states that have not expanded Medicaid have large populations of people of color, state decisions not to expand their programs disproportionately affect people of color, particularly Black Americans.¹⁵ 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.

There is no deadline for states to opt to expand Medicaid under the ACA and debate continues in some states about whether to expand. The November 2018 election led to additional states taking up the ACA Medicaid expansion,¹⁶ but subsequent political debate in some states has called into question the scale or structure of expansion.¹⁷ In addition, the Trump Administration has indicated to states that it is open to state Medicaid waiver proposals, which may lead some states that have not yet expanded Medicaid under the ACA to develop Medicaid expansion waivers and further extend coverage. However, some proposed waivers that could expand coverage for some people in the coverage gap also place new restrictions or requirements on that coverage.¹⁸ Thus, it is uncertain what insurance options, if any, adults in the coverage gap may have in the future, and these adults are likely to remain uninsured without policy action to develop affordable coverage options.

Table 1: Uninsured Adults in Non-Expansion States Who Would Be Eligible for Medicaid if Their States Expanded by Current Eligibility for Coverage, 2017

State	Total	Currently Eligible for Medicaid	Currently in the Coverage Gap (<100% FPL)	Currently May Be Eligible for Marketplace Coverage (100%-138% FPL**)
All States Not Expanding Medicaid	4,861,000	409,000	2,479,000	1,973,000
Alabama	235,000	12,000	140,000	83,000
Florida	884,000	48,000	445,000	392,000
Georgia	503,000	46,000	267,000	190,000
Kansas	86,000	6,000	46,000	34,000
Mississippi	176,000	13,000	103,000	61,000
Missouri	232,000	13,000	124,000	95,000
North Carolina	412,000	33,000	215,000	164,000
Oklahoma	216,000	19,000	111,000	85,000
South Carolina	240,000	30,000	124,000	86,000
South Dakota	32,000	3,000	20,000	9,000
Tennessee	244,000	37,000	113,000	94,000
Texas	1,498,000	89,000	759,000	649,000
Wisconsin*	79,000	57,000	0	22,000
Wyoming	24,000	N/A	12,000	9,000

NOTES: * Wisconsin provides Medicaid eligibility to adults up the poverty level under a Medicaid waiver. As a result, there is no one in the coverage gap in Wisconsin. ** The “100%-138% FPL” category presented here uses a Marketplace eligibility determination for the lower bound (100% FPL) and a Medicaid eligibility determination for the upper bound (138% FPL) in order to appropriately isolate individuals within the range of potential Medicaid expansions but also with sufficient resources to avoid the coverage gap. Totals may not sum due to rounding. N/A: Sample size too small for reliable estimate. SOURCE: KFF analysis based on 2018 Medicaid eligibility levels and 2017 American Community Survey.

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Data and Methods

This analysis uses data from the 2017 American Community Survey (ACS). The ACS provides socioeconomic and demographic information for the United States population and specific subpopulations. Importantly, the ACS provides detailed data on families and households, which we use to determine income and household composition for ACA eligibility purposes.

Medicaid and Marketplaces have different rules about household composition and income for eligibility. The ACS questionnaire captures the relationship between each household resident and one household reference person, but not necessarily each individual to all others. Therefore, prior to estimating eligibility, we implement a series of logical rules based on each person's relationship to that household reference person in order to estimate the person-to-person relationships of all individuals within a respondent household to one another. We then 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 spousal and parent-child relationships, aggregate Medicaid and Marketplace households, and then count income, see the detailed [Technical Appendix A](#).

Undocumented immigrants are ineligible for federally-funded Medicaid and Marketplace coverage. Since ACS 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.^{19,20} 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 ACS, controlling to state-level estimates of total undocumented population from Pew Research Center. For more detail on the immigration imputation used in this analysis, see the [Technical Appendix B](#).

Individuals in tax-filing units with access to an affordable offer of Employer-Sponsored Insurance (ESI) are still potentially MAGI-eligible for Medicaid coverage, but they are ineligible for advance premium tax credits in the Health Insurance Exchanges. Since ACS data do not designate policyholders of employment-based coverage nor indicate whether workers hold an offer of ESI, we developed a model that predicts both the policyholder and the offer of ESI based on the Current Population Survey (CPS). Additionally, for families with a Marketplace eligibility level below 250% FPL, we assume any reported worker offer does not meet affordability requirements and therefore does not disqualify the family from Tax Credit eligibility on the Exchanges. For more detail on the offer imputation used in this analysis, see the [Technical Appendix C](#).

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 reported eligibility levels as of January 1, 2018, updated to reflect state Medicaid expansion decisions as of December 2018 and 2017 Federal Poverty Levels.²¹ 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.²²

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.

Starting with our estimates of ACA eligibility in 2017, we transferred our core modeling approach from relying on the Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) to the American Community Survey. ACS includes a 1% sample of the US population and allows for precise state-level estimates as well as longer trend analyses. Since our methodology excludes a small number of individuals whose poverty status could not be determined, our ACS-based population totals appear slightly below CPS-based totals and some ACS population totals published by the Census Bureau. This difference is in large part attributable to students who reside in college dormitories. Comparing the two survey designs, CPS counts more of these individuals in the household of their parent(s) than ACS does.

Endnotes

¹ U.S. Department of Health and Human Services, Office of The Assistant Secretary for Planning and Evaluation, 2019 Poverty Guidelines. Available at: <https://aspe.hhs.gov/poverty-guidelines>.

² Kaiser Family Foundation State Health Facts, "Status of State Action on the Medicaid Expansion Decision," accessed February 2019, <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

³ \$9,172 a year for a family of three in 2019.

⁴ Of the states not moving forward with the expansion, only Wisconsin provides full Medicaid coverage to adults without dependent children. For state-by-state information on Medicaid eligibility, see The Kaiser Family Foundation State Health Facts. "Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level." Data Source: Based on state-reported eligibility levels as of January 1, 2018, collected through a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families. Available at: <http://kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/>.

⁵ National and state-by-state estimates of the number of people in the coverage gap may change from year to year due to several factors, including differences in the underlying data, small changes in state Medicaid eligibility, and declines in the number of uninsured people by state as economic conditions improve.

⁶ Kaiser Family Foundation analysis of the 2017 American Community Survey (ACS), 1-Year Estimates.

⁷ The "100%-138% FPL" category presented here uses a Marketplace eligibility determination for the lower bound (100% FPL) and a Medicaid eligibility determination for the upper bound (138% FPL) in order to appropriately isolate individuals within the range of potential Medicaid expansions but also with sufficient resources to avoid the coverage gap.

⁸ The vast majority of these people are eligible for tax credits to subsidize the cost of coverage in the Marketplace, though some (e.g., people with an offer of employer coverage) may not qualify for tax credits.

⁹ Ken Cannon, Jenna Burton, and MaryBeth Musumeci, *Adult Behavioral Health Benefits in Medicaid and the Marketplace* (Washington, D.C.: Kaiser Family Foundation, June 11, 2015), <https://www.kff.org/medicaid/report/adult-behavioral-health-benefits-in-medicaid-and-the-marketplace/>.

¹⁰ MaryBeth Musumeci, Julia Paradise, Erica L. Reaves, and Henry Claypool, *Benefits and Cost-Sharing for Working People with Disabilities in Medicaid and the Marketplace* (Washington, D.C.: Kaiser Family Foundation, October 15, 2014), <https://www.kff.org/medicaid/issue-brief/benefits-and-cost-sharing-for-working-people-with-disabilities-in-medicaid-and-the-marketplace/>.

¹¹ Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga, *The Effects of Medicaid Expansion on the ACA: Updated Findings From a Literature Review* (Washington, D.C.: Kaiser Family Foundation, March 2018), <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>.

¹² Ibid.

¹³ Kaiser Family Foundation, *Key Facts about the Uninsured Population* (Washington, D.C.: Kaiser Family Foundation, December 2018), <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

¹⁴ The methods for arriving at this estimate can be found on the Kaiser Family Foundation Subsidy Calculator and the Kaiser Family Foundation "Change in Average Marketplace Premiums by Metal Tier", available here: <http://www.kff.org/interactive/subsidy-calculator/> and <https://www.kff.org/health-reform/state-indicator/change-in-average-marketplace-premiums-by-metal-tier/>.

¹⁵ Samantha Artiga, Kendal Orgera, and Anthony Damico, *Changes in Health Coverage by Race and Ethnicity since Implementation of the ACA, 2013-2017* (Washington, D.C.: Kaiser Family Foundation, February 2019), <https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-implementation-of-the-aca-2013-2017/>.

¹⁶ Kaiser Family Foundation, *What Does the outcome of the Midterm Elections Mean for Medicaid Expansion?* (Washington, D.C.: Kaiser Family Foundation, November 2018), <https://www.kff.org/medicaid/fact-sheet/what-does-the-outcome-of-the-midterm-elections-mean-for-medicaid-expansion/>.

¹⁷ Robin Rudowitz and MaryBeth Musumeci, *“Partial Medicaid Expansion” with ACA Enhanced Matching Funds: Implications for Financing and Coverage* (Washington, D.C.: Kaiser Family Foundation, February 2019), <https://www.kff.org/medicaid/issue-brief/partial-medicaid-expansion-with-aca-enhanced-matching-funds-implications-for-financing-and-coverage/>.

¹⁸ Elizabeth Hinton, MaryBeth Musumeci, Robin Rudowitz, Larisa Antonisse, and Cornelia Hall, *Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers* (Washington, D.C.: Kaiser Family Foundation, February 12, 2019), <https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/>.

¹⁹ 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.

²⁰ Van Hook, J., Bachmeier, J., Coffman, D., and Harel, O. 2015. “Can We Spin Straw into Gold? An Evaluation of Immigrant Legal Status Imputation Approaches” *Demography*. 52(1):329-54.

²¹ Based on state-reported eligibility levels as of January 1, 2018. Eligibility levels are updated to reflect state implementation of the Medicaid expansion as of December 2018 and 2017 Federal Poverty Levels but may not reflect other eligibility policy changes since January 2018. The Kaiser Family Foundation State Health Facts. Data Source: Kaiser Family Foundation with the Georgetown University Center for Children and Families. Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey, (Washington, DC: Kaiser Family Foundation, March 21, 2018), Available at: <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2018-findings-from-a-50-state-survey/>.

²² 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 ACS 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 18% of poverty in states that are not expanding Medicaid. (See: MACPAC, *Medicaid Income Eligibility Levels as a Percentage of the FPL for Individuals Age 65 and Older and Persons with Disabilities by State, 2016*. Available at: <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-36.-Medicaid-Income-Eligibility-Levels-as-a-Percentage-of-the-FPL-for-Individuals-Age-65-and-Older-and-Persons-with-Disabilities-by-State-2016.pdf>).