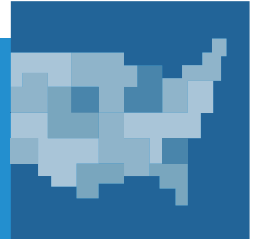


REPORT



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Trends in Medicaid and CHIP Eligibility Over Time

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Executive Summary

Over time eligibility for Medicaid and the Children’s Health Insurance Program (CHIP) has expanded to provide a base of coverage for the low-income population, which was most recently strengthened through the Affordable Care Act (ACA) Medicaid expansion as of 2014. While eligibility has increased over time, eligibility levels vary significantly across states and eligibility groups. This analysis examines trends in Medicaid and CHIP eligibility limits over time for children, pregnant women, parents, and other adults. It also explores how trends in eligibility for these groups vary by several variables, including geographic region, Medicaid expansion status, and state health ranking. (Eligibility levels for all 50 states and DC over time are available at <http://kff.org/data-collection/trends-in-medicaid-income-eligibility-limits/>.) Key findings include the following:

- **Eligibility for children and pregnant women has been consistently higher than for parents and other adults over time.** The ACA Medicaid expansion narrowed the gap between medians for these groups, but median eligibility limits for parents and other adults still are lower than those for children and pregnant women.
- **Across eligibility groups, the Northeast generally has had the highest median eligibility limits.** The South has the lowest median eligibility limits for all groups, except pregnant women, for whom the West has the lowest median eligibility limits. Over time, the gap between the region with the highest median eligibility limit and the region with the lowest median eligibility increased for children. This gap also widened for other adults when the Medicaid expansion took effect as of January 2014. In contrast, the gap between the highest and lowest regions has narrowed for parents and pregnant women over time.
- **States that implemented the Medicaid expansion have higher median eligibility limits compared to non-expansion states for all eligibility groups, and the gap between expansion and non-expansion states widened for all groups over time.** As expected, the largest differences emerged for parents and other adults after implementation of the expansion in 2014. However, the difference between the median income limit for children in expansion states and non-expansion states also grew over time. The gap is smaller for pregnant women and has recently begun to narrow.
- **For children, parents, and other adults, states with the lowest health rankings have the lowest median eligibility limits over time, while states with the highest health rankings have the highest median eligibility limits.** Gaps between median income eligibility limits for high and low health ranking states are largest for other adults and children. This gap also exists for parents, but it narrowed after implementation of the Medicaid expansion. For pregnant women, middle health ranking states have the highest median eligibility limits. While the high and low health ranking states have lower median eligibility limits compared to the middle health ranking states, the differences in median eligibility limits by health ranking are smaller for pregnant women compared to the other eligibility groups. These findings provide insight into how coverage levels vary by health needs; however, it is important to recognize that this is not a causal relationship given that health is impacted by a broad range of factors beyond health coverage and health care.

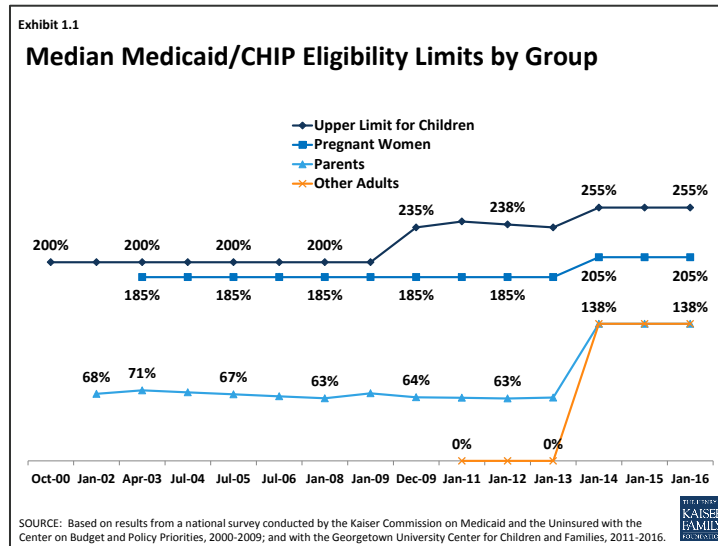
This analysis is based on 16 years of eligibility data collected by the Kaiser Commission on Medicaid and the Uninsured with the Center on Budget and Policy Priorities, 2000-2009; and with the Georgetown University Center for Children and Families, 2011-2015. The income eligibility limits are reported as a percentage of the

federal poverty level (FPL), which is calculated each year by the Department of Health and Human Services. As of 2015, the FPL is \$11,770 for an individual and \$20,090 for a family of three.

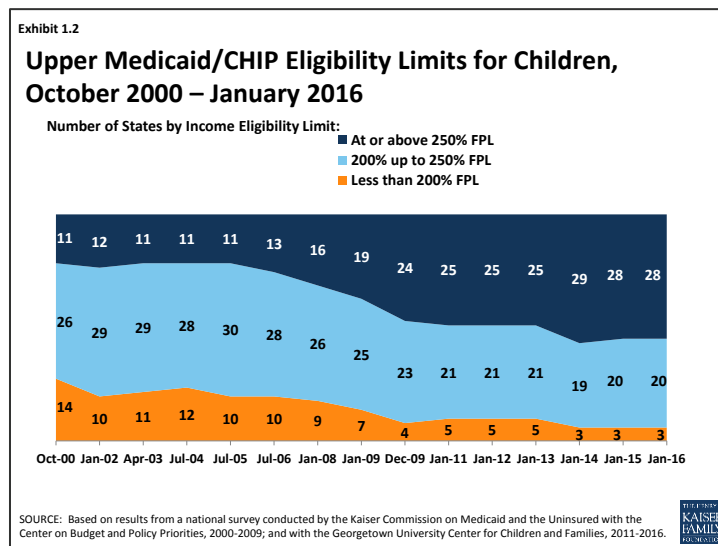
The data show changes in eligibility levels by group over time as well as the impact of the ACA on eligibility. Prior to the ACA, states generally could not receive federal Medicaid matching funds to cover non-disabled adults without dependent children. As enacted, the ACA expanded Medicaid eligibility to adults with incomes at or below 138% FPL beginning in 2014, although this provision was effectively made a state option by the Supreme Court's 2012 ruling on the ACA. Other eligibility changes established by the ACA went into effect across all states as of January 1, 2014, including establishing a new minimum eligibility level of 138% FPL for children of all ages in Medicaid and changing the method for determining financial eligibility for Medicaid for children, pregnant women, parents, and adults and CHIP to a standard based on modified adjusted gross income (MAGI). As such, the changes in eligibility levels between 2013 and 2014 reflect both changes in eligibility policy, including adoption of the Medicaid expansion, as well as the conversion to the MAGI-based standards. While many of the converted 2014 standards appear higher than 2013 levels, the converted thresholds are intended to approximate states' existing eligibility levels using different methodology for determining income.

Section 1: Eligibility Trends by Group

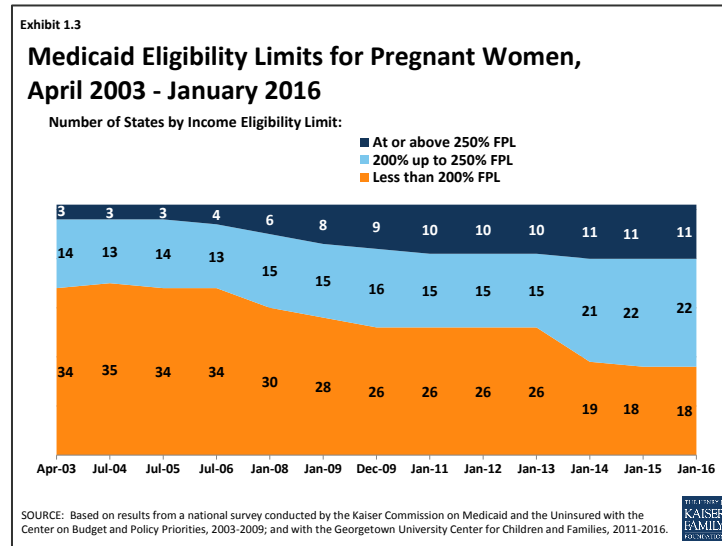
Eligibility for children and pregnant women has been consistently higher than for parents and other adults over time, reflecting both higher federal minimums and state take up of options to expand eligibility for these groups, including coverage under CHIP (Exhibit 1.1). Median eligibility levels for each eligibility group have increased over time. The Medicaid expansion narrowed the gap between median eligibility limits for parents and other adults and children and pregnant women beginning in 2014, but median eligibility limits for parents and other adults still remain below those for children and pregnant women.



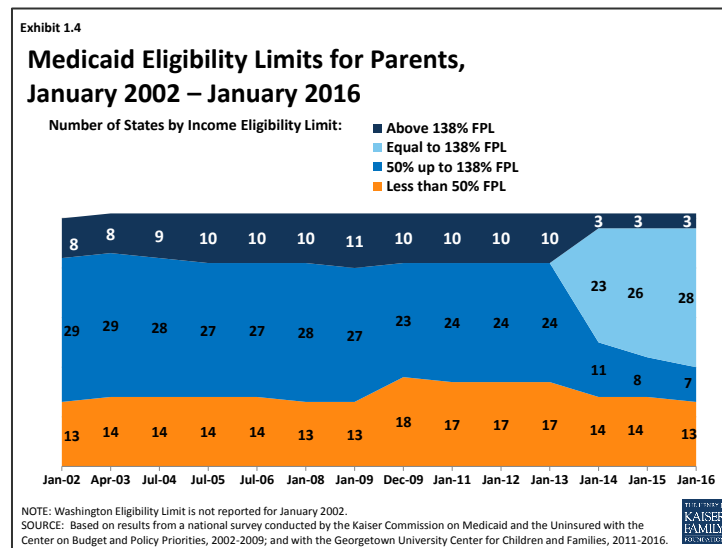
Children. For children, the number of states that limit eligibility to less than 200% FPL decreased from 14 to 3 between 2000 and 2016, while the number of states extending eligibility to children with incomes at 250% FPL or higher grew from 11 to 28 over the period (Exhibit 1.2).



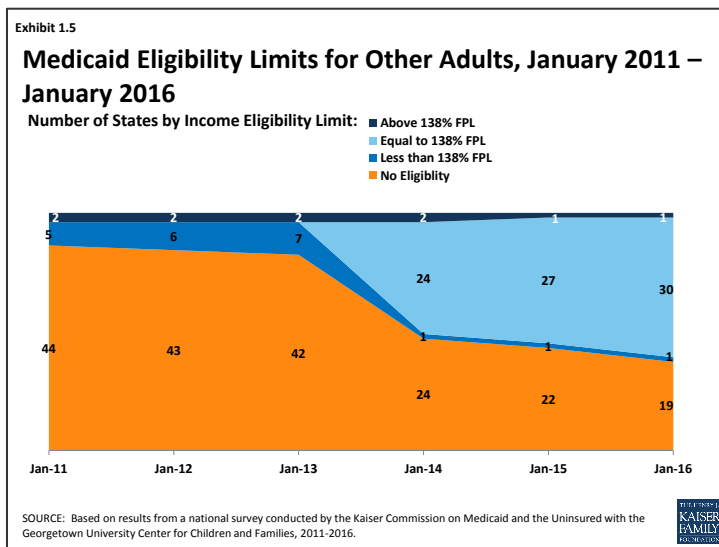
Pregnant women. Similar patterns were observed for pregnant women. The number of states limiting eligibility to less than 200% FPL decreased from 34 to 18 between 2003 and 2016, and the number of states covering pregnant women with incomes at or above 250% FPL rose from 3 to 11 (Exhibit 1.3).



Parents. Parent eligibility levels across states remained low and fairly stable over the study period prior to the Medicaid expansion (Exhibit 1.4). The Medicaid expansion significantly increased the number of states covering parents at or above 138% FPL. However, 13 of the 20 states that had not implemented the expansion as of January 2016 still had eligibility limits for parents that were less than 50% FPL.

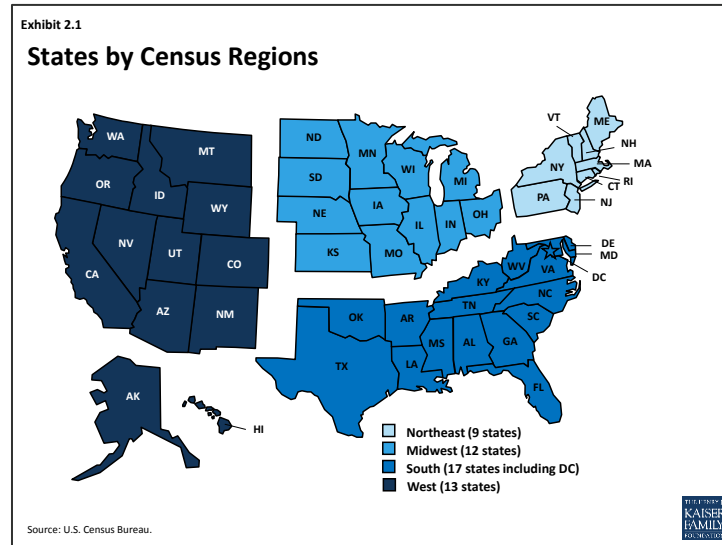


Other adults. Other adults remained ineligible for Medicaid in the majority of states prior to the Medicaid expansion, reflecting the fact that states could not cover these adults through Medicaid prior to the ACA unless they obtained a waiver (Exhibit 1.5). The Medicaid expansion significantly increased the number of states covering these adults beginning in 2014, but they remain ineligible in all of the non-expansion states, with the exception of Wisconsin, which covers adults up to 100% FPL.

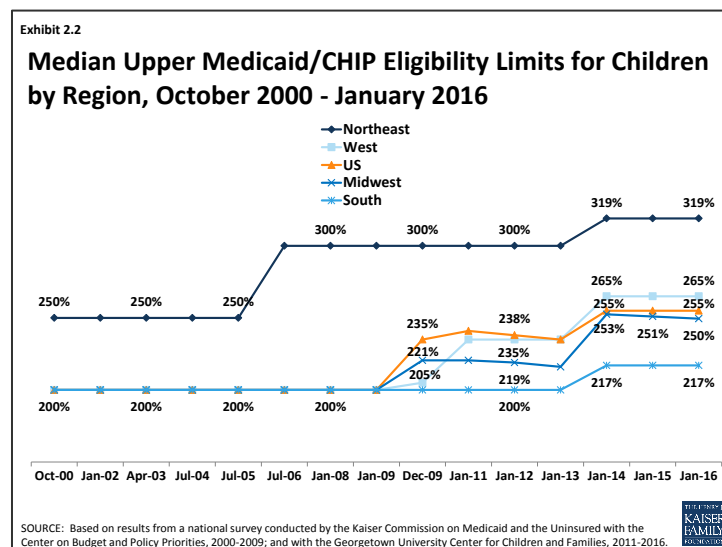


Section 2: Eligibility Trends by Geographic Region

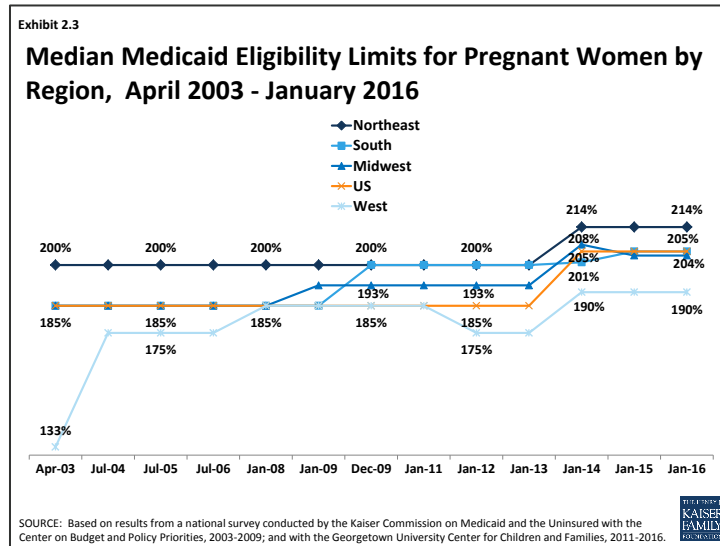
This section examines trends in eligibility by U.S. Census region, including the Northeast, South, Midwest, and West (Exhibit 2.1). Across eligibility groups, the Northeast generally has had the highest median eligibility limits over time. The South has had the lowest median eligibility limits for all groups, except pregnant women, for whom the West has the lowest median eligibility limits. Over the study period, the gap between the region with the highest median eligibility limit and the region with the lowest median eligibility increased for children. Similarly, the gap between the region with the highest and lowest median limit widened for other adults when the Medicaid expansion took effect as of January 2014. In contrast, this gap between the highest and lowest regions has narrowed for parents and pregnant women over time.



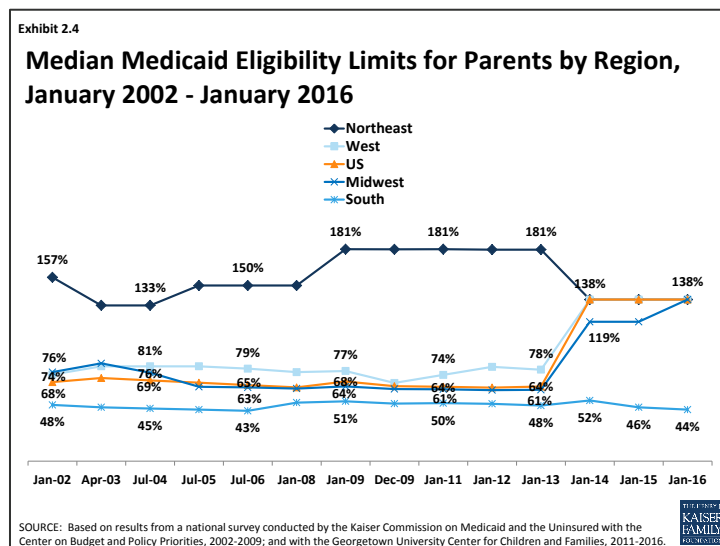
Children. Between 2000 and 2016, median eligibility limits for children increased in all regions, but the increase in the South only reflects the conversion to MAGI-based thresholds beginning as of January 2014 (Exhibit 2.2). Increases were largest and occurred earliest in the Northeast. Median limits in the West also increased over the period, rising above the U.S. median. Smaller increases occurred in the Midwest, which remains below the U.S. median as of 2016.



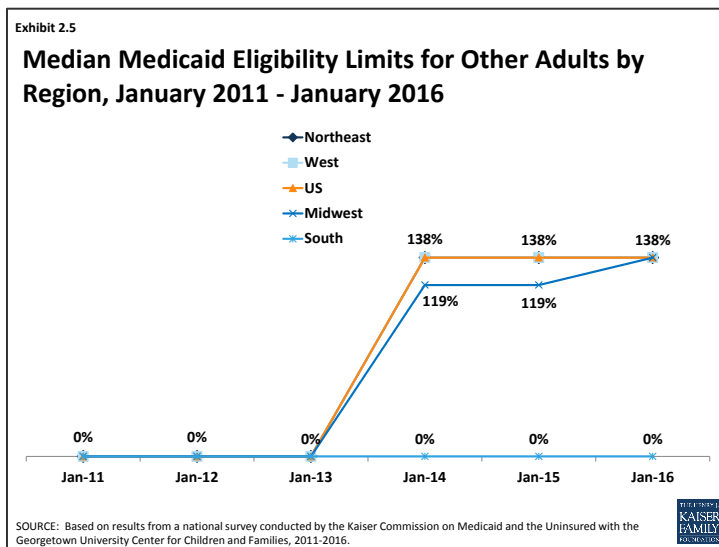
Pregnant women. Median eligibility limits for pregnant women increased in all regions between 2003 and 2016 (Exhibit 2.3). The largest increase occurred in the West, although the median limit for the region still remains below the U.S. median as of 2015.



Parents. Changes in median eligibility limits for parents between 2002 and 2016 varied across the regions (Exhibit 2.4). In the Midwest and West, median eligibility limits for parents significantly increased as of 2014 due to the Medicaid expansion. In the Northeast, the median decreased from 157% FPL to 138% FPL, reflecting Medicaid eligibility reductions in several states when parents above 138% FPL became eligible for new Marketplace coverage options as of 2014. In the South, the median eligibility limit remained relatively stable and low, at around half the poverty level, since most states in the region did not adopt the Medicaid expansion.

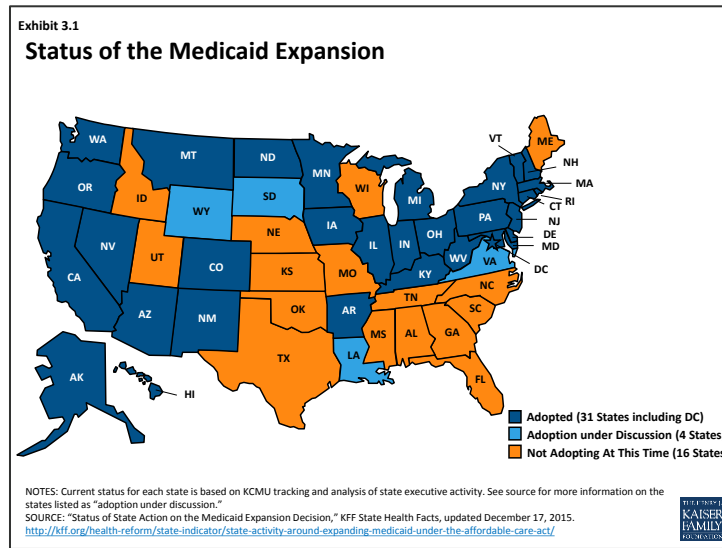


Other adults. Median eligibility limits for other adults substantially increased between 2011 and 2016 in all regions except the South (Exhibit 2.5). In the Northeast, Midwest, and West, the median limit increased from 0% FPL to 138% FPL, reflecting adoption of the Medicaid expansion in most states in these regions. In the South, the median eligibility limit remains at 0% FPL since most states in the region have not adopted the expansion as of January 2016.



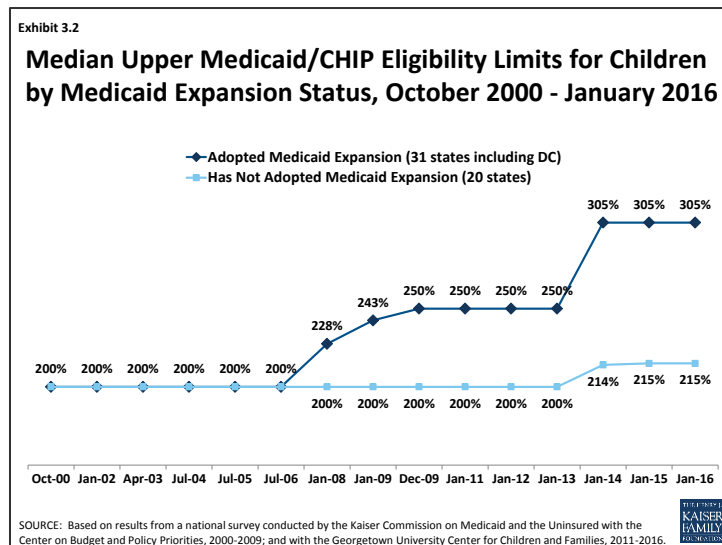
Section 3: Eligibility Trends by Medicaid Expansion Status

This section analyzes trends in eligibility by the status of implementation of the Medicaid expansion as of January 2016, which is the most recent date of the eligibility data in this analysis (Exhibit 3.1).

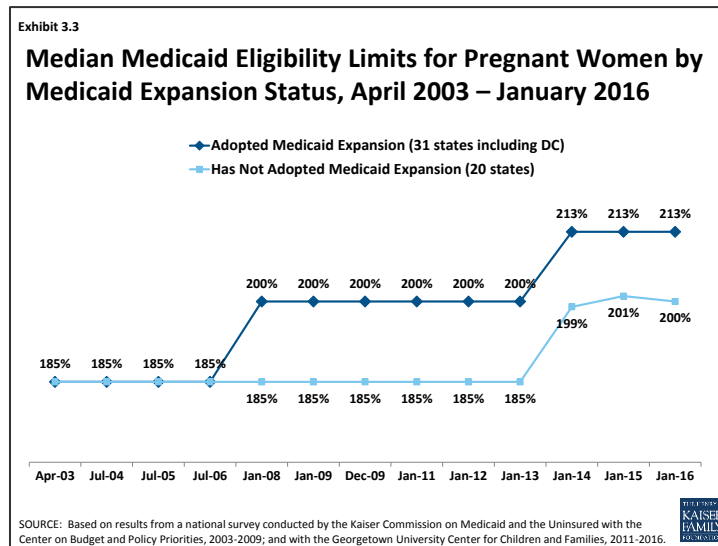


States that implemented the Medicaid expansion had higher median eligibility limits compared to non-expansion states across eligibility groups. Over time, the difference between median eligibility limits for expansion and non-expansion states widened for all eligibility groups. As expected, the largest differences emerged for parents and other adults after implementation of the expansion in 2014. However, the difference between the median eligibility limit for children in expansion states and non-expansion states also grew over time. The gap is smaller for pregnant women and has recently begun to narrow.

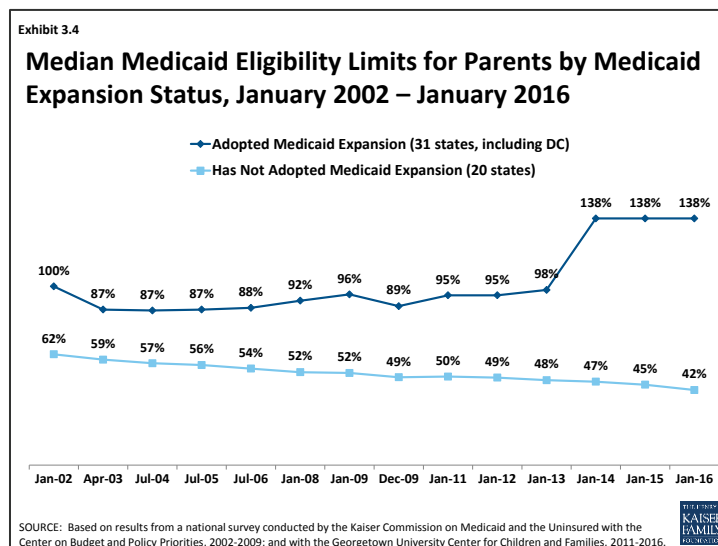
Children. Between 2000 and 2016, median eligibility limits for children increased in Medicaid expansion states (Exhibit 3.2). The median eligibility limit for non-expansion states remained unchanged, except for the increase in 2014 that reflected the conversion to MAGI-based standards.



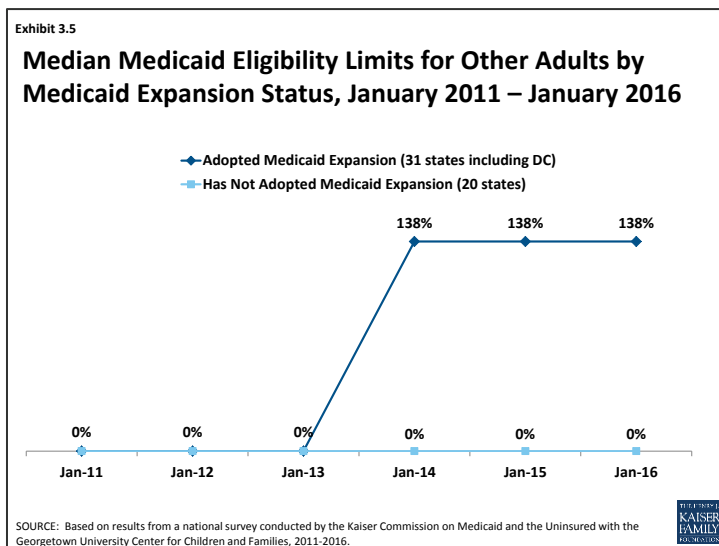
Pregnant women. Similarly, median eligibility limits for pregnant women increased in expansion states between 2003 and 2016, while there was a smaller increase in non-expansion states (Exhibit 3.3). This change in the non-expansion states reflected the conversion to MAGI-based standards as of 2014 and the reinstatement of coverage for pregnant women up to 205% FPL in Virginia as of 2015.



Parents. For parents, median eligibility limits increased in expansion states but declined in non-expansion states between 2002 and 2016, leading to a widening gap over time (Exhibit 3.4). In the Medicaid expansion states, median eligibility limits for parents increased from 100% to 138% FPL, reflecting the fact that many of these states took up options to expand coverage for parents above minimum thresholds prior to the Medicaid expansion. In non-expansion states, the median parent eligibility limit remained low and decreased post-ACA, reflecting eligibility reductions in some states as well as continued erosion of the eligibility limit in some states that base eligibility on a dollar threshold that does not update over time.

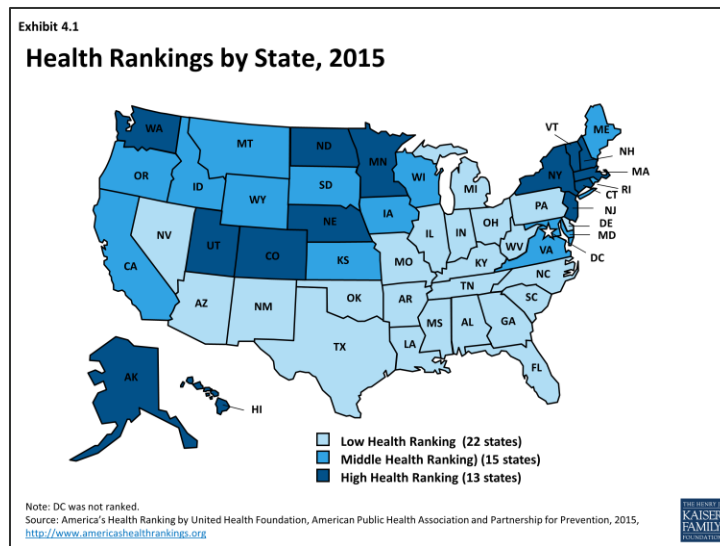


Other adults. For other adults, the median eligibility limit rose from 0% to 138% FPL in expansion states between 2011 and 2016, while the median limit remains at 0% FPL in non-expansion states (Exhibit 3.5). Adults without dependent children are ineligible for Medicaid in all of the non-expansions states except Wisconsin, which covers adult up to 100% FPL.



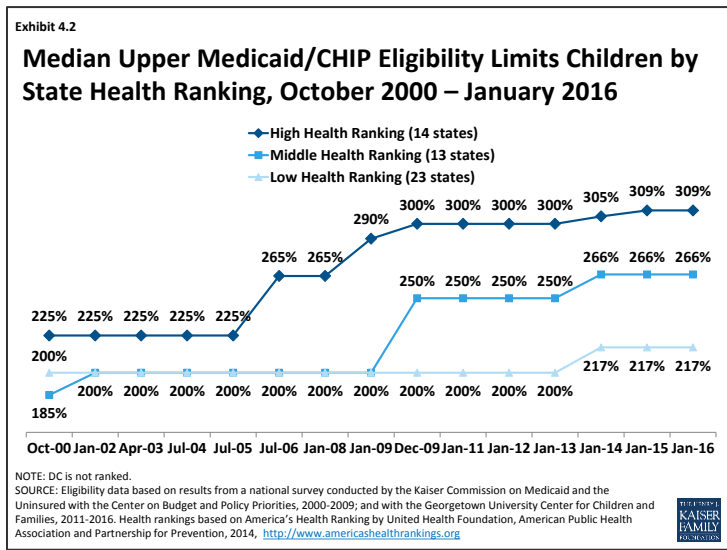
Section 4: Eligibility Trends by State Health Ranking

This section analyzes trends in eligibility over time by state health ranking. While these findings provide insight into how coverage levels vary by health needs, it is important to recognize that this is not a causal relationship given that health is impacted by a broad range of factors beyond health coverage and health care. State health rankings were based on the 2015 America's Health Rankings report, which includes data for all 50 states, but not DC. America's Health Ranking is produced annually by United Health Foundation, the American Public Health Association and the Partnership for Prevention (available at <http://www.americashealthrankings.org/>). The rankings are developed based on four groups of health determinants, including: behaviors, community & environment, policy and clinical care, and several measures of health outcomes. An overall health score is created for each state based on how they fare on each measure compared to the national average. (See Appendix B for more details.) For this analysis, states were categorized into three groups based on their health ranking scores. A total of 22 states with a negative score were classified as low health ranking states, 15 states with scores between 0 and .39 were grouped as middle health ranking states, and 13 states with scores above .40 were categorized as high health ranking states (Exhibit 4.1).

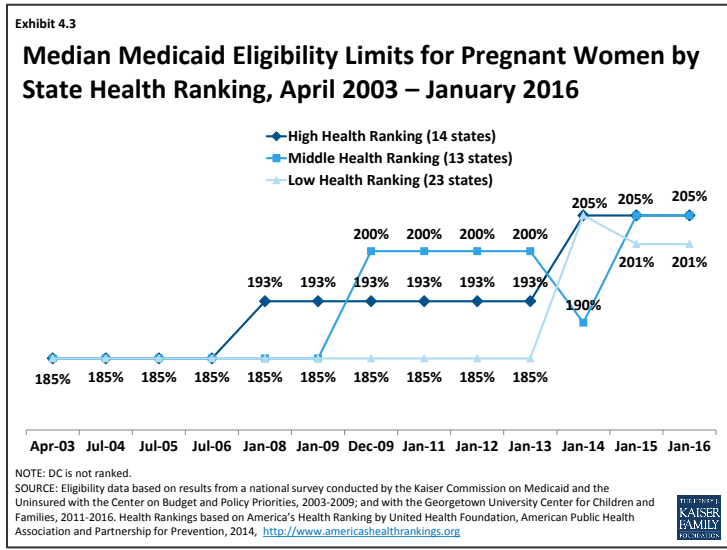


For children, parents, and other adults, states with the highest health rankings generally have the highest median eligibility limits over time. Differences between median eligibility limits by health ranking are largest for children, but have narrowed over time for other groups.

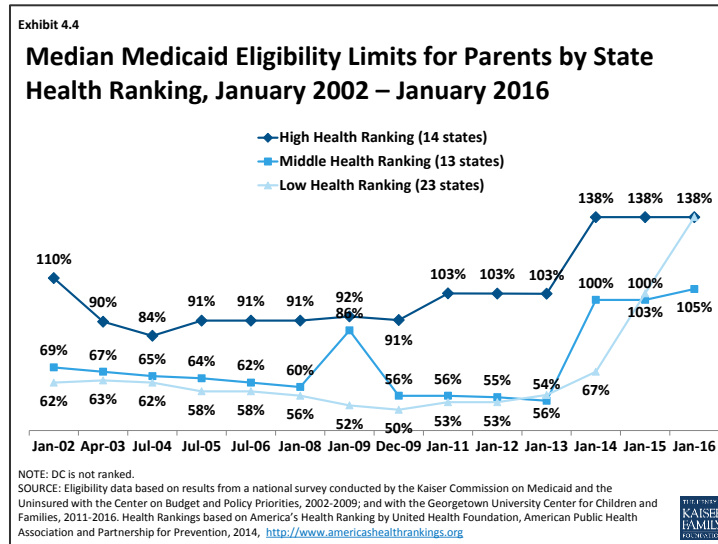
Children. Between 2000 and 2015, median eligibility limits for children increased in high and middle health ranking states (Exhibit 4.2). Increases were largest and occurred earlier in high health ranking states compared to the middle health ranking states. Median eligibility limits did not change in the low health ranking states except for the conversion to MAGI-based standards as of January 2014.



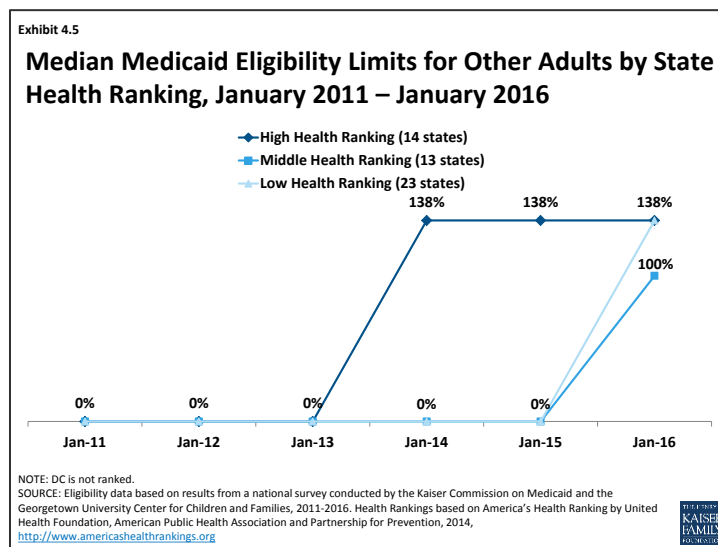
Pregnant women. For pregnant women, there were increases in median eligibility limits for high, middle, and low-ranking states between 2003 and 2016 (Exhibit 4.3). The increases occurred earliest in high ranking health ranking states as of 2008, following by middle health ranking states at the end of 2009, and then last by low-ranking states in 2013. Reflecting these increases, the differences in median eligibility limits between high, middle, and low health ranking states are narrow as of January 2016.



Parents. Median eligibility limits for parents increased between 2002 and 2016 across all three groups of states (Exhibit 4.4). States with high health rankings started with higher eligibility limits as of 2002 compared to the middle and low health ranking states, and remained the highest as of 2016. The middle and low health ranking states generally had similar median eligibility limits throughout the study period with an increase beginning in 2014 when the Medicaid expansion took effect. This increase narrowed the gap in eligibility limits between high and middle and low ranking states.



Other adults. The high health ranking states were the first group to show an increase in the median eligibility limit for other adults between 2011 and 2016, increasing from 0% FPL to 138% FPL as of January 2014 when the Medicaid expansion took effect (Exhibit 4.5). This increase reflects adoption of the Medicaid expansion in most of the states that have a high health ranking as of January 2014. In contrast, the median eligibility limit for middle and low health ranking states remained at 0% FPL through 2015. However, as a result of additional states implementing the expansion during 2015, their median limits rose as of January 2016 and the gap in eligibility limits between high, middle, and low health ranking states narrowed.



Conclusion

Together these data show that over time Medicaid and CHIP eligibility levels have increased for all eligibility groups. However, there eligibility levels vary substantially across states and across eligibility groups. Eligibility remains higher for pregnant women and children compared to parents and other adults. Moreover, there generally have been widening disparities in access to coverage across states when examining them by geographic region and Medicaid expansion status. In contrast, for most groups, differences in median eligibility limits by state health ranking have narrowed over time.

Appendix A

Table 1: States by Region, Medicaid Expansion Status, and Health Ranking			
State	Region	Medicaid Expansion Status	Health Ranking
Alabama	South	Has Not Adopted	Low
Alaska	West	Implemented	Middle
Arizona	West	Implemented	Low
Arkansas	South	Implemented	Low
California	West	Implemented	Middle
Colorado	West	Implemented	High
Connecticut	Northeast	Implemented	High
Delaware	South	Implemented	Low
DC	South	Implemented	Not Ranked
Florida	South	Has Not Adopted	Low
Georgia	South	Has Not Adopted	Low
Hawaii	West	Implemented	High
Idaho	West	Has Not Adopted	Middle
Illinois	Midwest	Implemented	Low
Indiana	Midwest	Implemented	Low
Iowa	Midwest	Implemented	Middle
Kansas	Midwest	Has Not Adopted	Middle
Kentucky	South	Implemented	Low
Louisiana	South	Has Not Adopted	Low
Maine	Northeast	Has Not Adopted	Middle
Maryland	South	Implemented	Middle
Massachusetts	Northeast	Implemented	High
Michigan	Midwest	Implemented	Low
Minnesota	Midwest	Implemented	High
Mississippi	South	Has Not Adopted	Low
Missouri	Midwest	Has Not Adopted	Low
Montana	West	Implemented	Middle
Nebraska	Midwest	Has Not Adopted	High
Nevada	West	Implemented	Low
New Hampshire	Northeast	Implemented	High
New Jersey	Northeast	Implemented	High
New Mexico	West	Implemented	Low
New York	Northeast	Implemented	Middle
North Carolina	South	Has Not Adopted	Low
North Dakota	Midwest	Implemented	High
Ohio	Midwest	Implemented	Low
Oklahoma	South	Has Not Adopted	Low
Oregon	West	Implemented	High
Pennsylvania	Northeast	Implemented	Middle
Rhode Island	Northeast	Implemented	Middle
South Carolina	South	Has Not Adopted	Low
South Dakota	Midwest	Has Not Adopted	Middle
Tennessee	South	Has Not Adopted	Low
Texas	South	Has Not Adopted	Low
Utah	West	Has Not Adopted	High
Vermont	Northeast	Implemented	High
Virginia	South	Has Not Adopted	Middle
Washington	West	Implemented	High
West Virginia	South	Implemented	Low
Wisconsin	Midwest	Has Not Adopted	Middle
Wyoming	West	Has Not Adopted	Middle

Sources: Regions based on U.S. Census Bureau, Medicaid expansion based on KCMU analysis, health ranking based on “America’s Health Ranking state health scores, 2015.”

Appendix B: Overview of America's Health Rankings

America's Health Ranking is produced annually by United Health Foundation, the American Public Health Association and the Partnership for Prevention (<http://www.americashealthrankings.org/>). The health rankings for states are developed based on four groups of health determinants, including: behaviors, community & environment, policy and clinical care, and several measures of health outcomes.

The overall health score is calculated by adding the score of each measure multiplied by the measure weight (see Table 2). The ranking is the order of each state according its overall score; ties in values are assigned equal rankings.

The score for each measure is a representation of the number of standard deviations a state is above or below the national mean. The national mean is set at the average value of the states and DC. It is calculated by:

Score = (State value – National mean)/Standard Deviation of all state values.

This is commonly known as a “Z-score”. The score is stated as a decimal ranging from positive to negative 2. Higher scores mean that a state has a higher value than the national average, while lower scores mean that the state has a lower value than the national average. Table 2 shows whether a higher value has a negative or a positive impact on the health ranking.

Table 2: Measures, Weights, and Sources for America's Health Rankings Scores, 2015

Name of Measure	% of Score	Effect on Score	Source
Behaviors	25.0		
Smoking (% of adult population)	7.5	Negative	Behavioral Risk Factors Surveillance System (BRFSS), 2014
Binge Drinking (% of adult population)	2.5	Negative	BRFSS 2014
Drug Deaths (Deaths/100,000)	2.5	Negative	National Vital Statistics System, 2011 – 2013
Obesity (% of adult population)	5.0	Negative	BRFSS, 2014
Physical Inactivity (%of adult population)	2.5	Negative	BRFSS, 2014
High School Graduation (%of incoming 9 th graders)	5.0	Positive	National Center for Education Statistics, 2012 – 2013
Community & Environment	22.5		
Violent Crime (Offenses/100,000)	5.0	Negative	Federal Bureau of Investigation, 2013
Occupational Fatalities (Deaths/100,000 workers)	2.5	Negative	Census of Fatal Occupational Injuries, 2012 – 2014 P&US Bureau of Economic Analysis
Infectious Disease (Combined score for Chlamydia, Pertussis, and Salmonella cases/100,000)	5.0	Negative	Summary of Notifiable Disease, 2013 & NCHHSTP Atlas, 2013
Children in Poverty (% of children)	5.0	Negative	2014 Annual Social and Economic Supplement, 2014
Air Pollution (Micrograms of fine particles/ cubic meter)	5.0	Negative	Environmental Protection Agency, 2012 – 2014
Public & Health Policies	12.5		
Lack of Health Insurance (% of population)	5.0	Negative	American Community Survey, 2013 – 2014
Public Health Funding (Dollars/person)	2.5	Positive	Trust for America's Health, 2013 – 2014
Immunization – Children (% aged 19 to 35 mos)	2.5	Positive	National Immunization Survey, 2014
Immunization – Adolescents (% aged 13 to 17 yrs)	2.5	Positive	National Immunization Survey, 2014
Clinical Care	15.0		
Low Birthweight (Percent of live births)	3.75	Negative	National Vital Statistics System, 2013
Primary Care Physicians (Number/100,000)	3.75	Positive	American Medical Association, 2013
Dentists (Number/100,000)	3.75	Positive	American Dental Association, 2013
Preventable Hospitalizations (Number /1,000 Medicare beneficiaries)	3.75	Negative	Darmouth Atlas, 2013
Outcomes	25.0		
Diabetes (Percent of adult population)	3.125	Negative	BRFSS, 2014
Poor Mental Health Days (Days in previous 30 days)	3.125	Negative	BRFSS, 2014
Poor Physical Health Days (Days in previous 30 days)	3.125	Negative	BRFSS, 2014
Disparity in Health Status (Percent difference by education level)	3.125	Negative	BRFSS, 2014
Infant Mortality (Deaths per 1,000 live births)	3.125	Negative	National Vital Statistics System, 2012 – 2013
Cardiovascular Deaths (Deaths/100,000)	3.125	Negative	National Vital Statistics System, 2011 – 2013
Cancer Deaths (Deaths/100,000)	3.125	Negative	National Vital Statistics System, 2011 – 2013
Premature Deaths (Years lost/100,000)	3.125	Negative	National Vital Statistics System, 2013



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