NC RHRP

Findings Brief
NC Rural Health Research Program

July 2014

How Does Medicaid Expansion Affect Insurance Coverage of Rural Populations?

Kristie Thompson, MA; Brystana Kaufman; Mark Holmes, PhD

BACKGROUND

When passed, the Affordable Care Act (ACA) required states to expand Medicaid to provide coverage for adults ages 18-64 with incomes up to 138% of the federal poverty level (FPL).[1] However, in June 2012, the Supreme Court ruled that the mandatory Medicaid expansion was unconstitutionally coercive to the states, effectively making the Medicaid expansion optional. As of March 2014, 26 states[2] (including the District of Columbia) had decided to expand Medicaid.[3] Expanding Medicaid to cover all uninsured adults living below 138% FPL was a key component of the ACA, and without the expansion, an estimated five million adults will fall in a coverage gap[4] because they will not qualify for Medicaid or federal health insurance tax credits. Due to historically higher rates of poverty, uninsurance and higher enrollment in Medicaid in rural areas,[5] there is concern that the Supreme Court's decision may have disproportionate effects on the more rural states, leaving larger numbers and proportions of the population without health care coverage.

KEY FINDINGS

- Fewer rural states have expanded Medicaid. A majority of the states with the largest percentage of population living in rural areas are not expanding, while nearly all of the least rural states are expanding.
- States with a higher percentage of their rural (nonmetro) population living in poverty are less likely to expand. More nonmetro residents would potentially be eligible for Medicaid due to the lower income in these states.
- The majority of rural residents live in a state without plans to expand Medicaid. Only three of the 11 states with the largest rural population (> 500,000) have expanded their Medicaid programs (IA, KY, MI).
- Interstate variation in Medicaid expansion decisions has led to a wider rural-urban disparity in insurance coverage than existed pre-ACA or would exist under universal Medicaid expansion. Implementing the ACA with complete Medicaid expansion is estimated to produce the lowest and most equitable estimates of uninsured in all geographic areas—reducing the percentage of uninsured by more than half of what it was in all areas before ACA. Currently, however, the state variation in expansion decisions has exacerbated the nationwide gap in insurance coverage.

To better understand how states' decisions on Medicaid expansion are impacting rural areas in the U.S., we used population estimates, current status of state expansion, and state-level insurance estimates to answer two primary questions: 1) How is Medicaid expansion affecting rural populations, and 2) How would it differ if every state were to expand? In this brief, counties are classified as metropolitan, micropolitan, or noncore based on the 2013 Office of Management and Budget designations.[6] We use "rural" or "noncore" to refer to counties not in a metropolitan or micropolitan statistical area and "nonmetro" to refer to counties outside a metropolitan area.

RESULTS

State Decisions on Medicaid Expansion

Rural states are not as likely to expand Medicaid. Table 1 presents state Medicaid expansions by population and percent of state populations living in rural areas. More than half (six of the 11) of the most rural states (> 20% of state population in rural—noncore—areas) have not expanded Medicaid (AK, ME, MS, MT, SD, and WY), while 14 of the 15 of the least rural states (< 3.0% of population in rural areas) have expanded. Likewise, eight of the 11 states with the largest number of rural residents (> 500,000) have not expanded Medicaid (AL, GA, MO, MS, NC, TN, TX, and WI). Only three of the 11 states with the largest rural populations have expanded their Medicaid programs (IA, KY, MI). The tendency of the more rural states not to expand has been noted previously,[7] and the slightly different data sources used here lead to similar conclusions.

Table 1: State Medicaid Expansion Decisions by Percent Rural Population and Total Rural Population

State	Rural Population Percent*	Rural Population Number*	Expanding Medicaid
MT	34.4	289,208	No/not yet
ME	31.6	346,852	No/not yet
WY	26.7	131,042	No/not yet
AK	26.5	87,764	No/not yet
ND	26.4	151,925	Yes
VT	25.9	134,019	Yes
SD	25.6	177,830	No/not yet
IA	24.9	639,876	Yes
KY	22.6	840,116	Yes
MS	22.4	569,706	No/not yet
WV	22.0	335,745	Yes
AR	19.1	473,273	Yes
NE	17.4	274,327	No/not yet
OK	13.8	446,632	No/not yet
MO	13.4	681,379	No/not yet
KS	13.1	322,619	No/not yet
AL	12.9	527,143	No/not yet
WI	12.1	590,189	No/not yet
MN	10.3	473,496	Yes
TN	9.7	529,905	No/not yet
VA	9.1	315,693	No/not yet
ID	8.2	112,285	No/not yet
LA	7.5	294,669	No/not yet
GA	7.4	636,310	No/not yet
IN	7.0	392,102	No/not yet
SC	6.7	263,109	No/not yet
MI	6.4	537,990	Yes
NC	6.3	519,194	No/not yet
CO	5.5	246,559	Yes
TX	4.9	1,115,716	No/not yet
UT	4.8	121,915	No/not yet
IL	4.5	496,463	Yes
NM	4.2	76,192	Yes
OH	3.9	386,603	Yes
NH	3.4	37,971	No/not yet
PA	3.2	334,560	No/not yet
OR	2.3	77,058	Yes
NY	2.0	324,433	Yes
WA	2.0	120,499	Yes
AZ	1.6	87,184	Yes
FL	1.6	254,702	No/not yet
MD	1.4	68,843	Yes

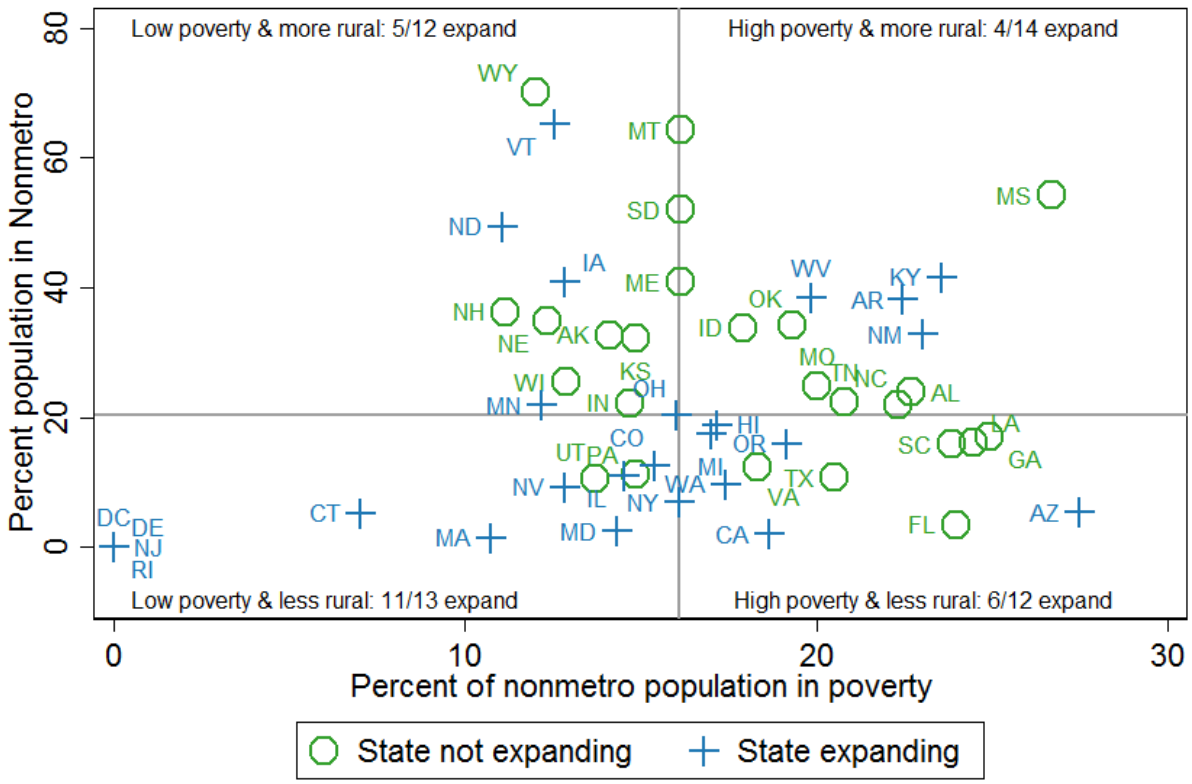
Table 1 (continued): State Medicaid Expansion Decisions by Percent Rural Population and Total Rural Population

State	Rural Population Percent*	Rural Population Number*	Expanding Medicaid
NV	1.1	25,323	Yes
CA	0.7	220,690	Yes
MA	0.2	8,898	Yes
CT	0	0	Yes
DC	0	0	Yes
DE	0	0	Yes
HI	0	0	Yes
NJ	0	0	Yes
RI	0	0	Yes

*Shaded cells denote the 11 states with greater than 20% of population living in noncore areas (2nd column) and the 11 states with at least 500,000 noncore residents (3rd column).

Because Medicaid expansion is more likely to affect low-income populations, we calculated the percent of the rural (nonmetro) population in each state living at or below 100% FPL. Rural, poor states are the least likely to expand Medicaid. Figure 1 presents the percent of the population living in nonmetro areas (y-axis) against the nonmetro population living in poverty (x-axis) with medians shown. States in the upper right quadrant are more rural and are poorer than states in the bottom left quadrant. Expansion decisions are denoted with a circle (no expansion) and a plus sign (expansion). The least rural, lowest poverty states are the most likely to expand (11 out of 13 states expanded), while the most rural, highest poverty states are least likely to expand (4 out of 14 states expanded).

Figure 1: Rural, Poor States Are the Least Likely to Expand Medicaid

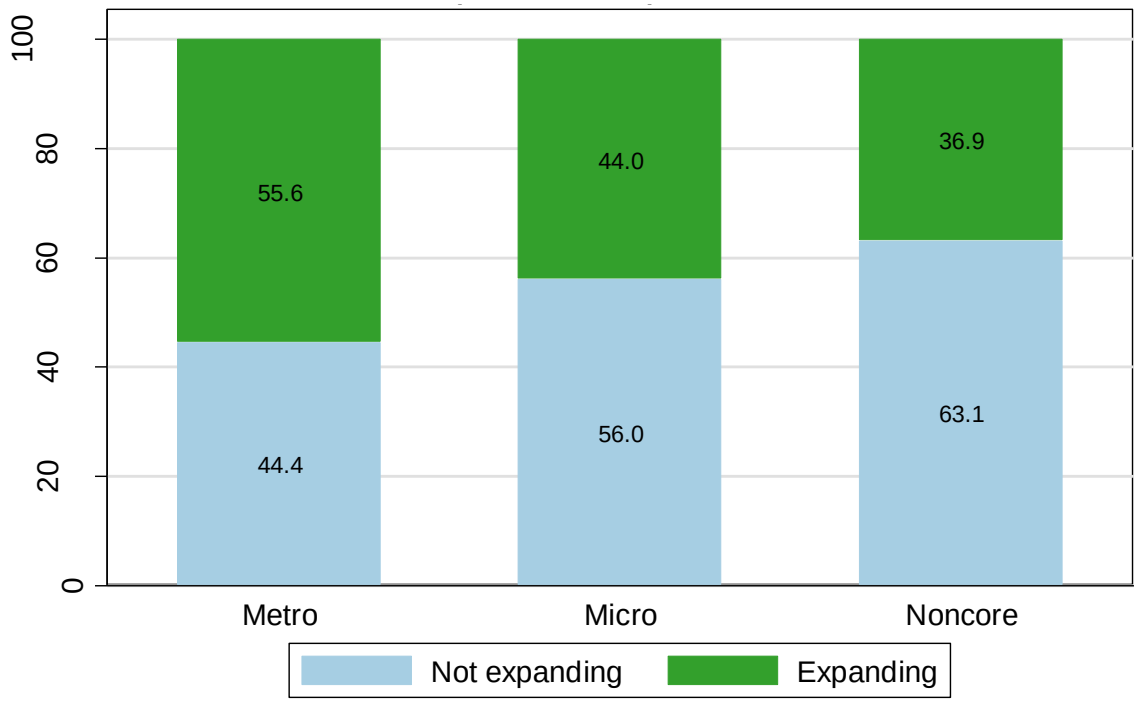


Note: DE, DC, NJ, and RI have no nonmetro population; poverty rate displayed as 0.
Grey lines denote medians.

The Majority of Rural Residents Live in a State Currently without Plans to Expand Medicaid

Figure 2 shows that both micropolitan and noncore residents are more likely to live in states that do not have plans to expand Medicaid. Specifically, 56% of the population in micropolitan areas and 63% of the population in noncore areas live in a state that has not expanded Medicaid. More than half (55.6%) of urban residents, on the other hand, live in a state that has expanded Medicaid.

Figure 2: Medicaid Expansion and Percent of Population in Rural Areas



How State Medicaid Expansion Decisions Are Affecting the Percent Uninsured in Rural Areas

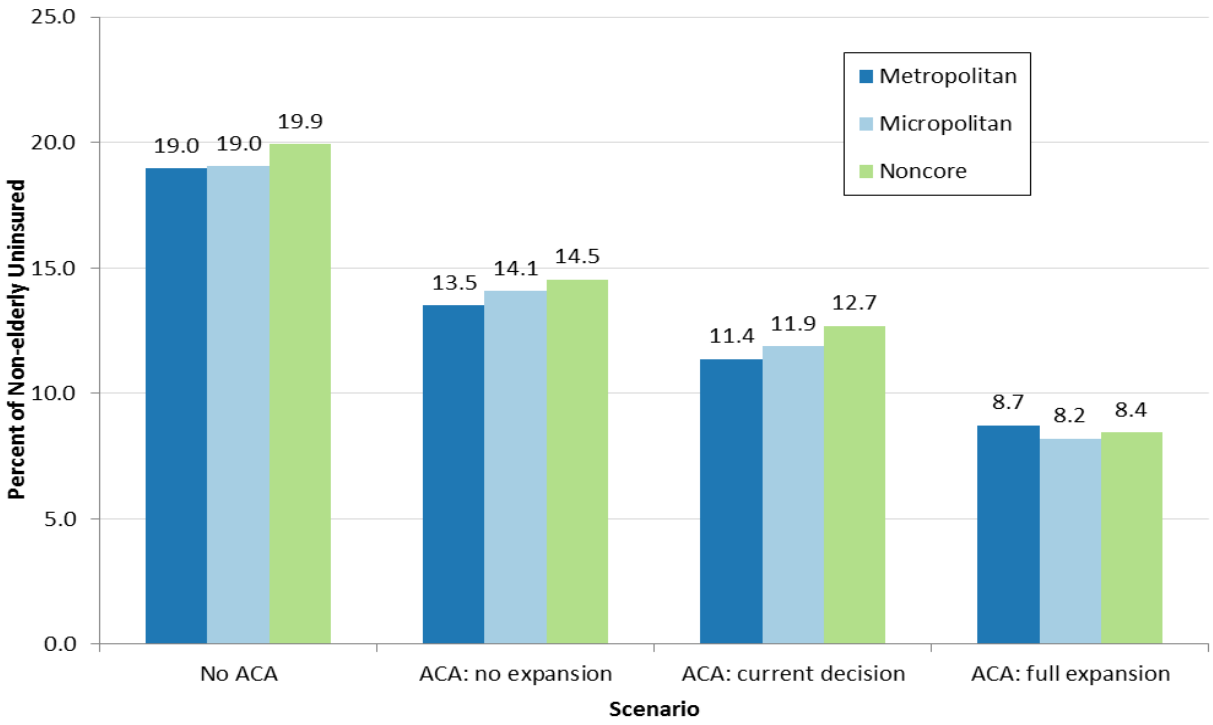
To determine the impact that various levels of Medicaid expansion would have on states' uninsured populations, we projected insurance coverage at the county level for four different ACA scenarios.

1) Percent of non-elderly who are uninsured before the ACA was implemented
2) Estimated percent of non-elderly who are uninsured with ACA implemented, but without Medicaid expansion in any state
3) Estimated percent of the non-elderly who are uninsured with our current situation [ACA and partial Medicaid expansion (25 states plus DC expand)]
4) Estimated percent of the non-elderly who are uninsured with ACA and complete Medicaid expansion

Figure 3 shows that complete Medicaid expansion produces the lowest and most equitable estimates of uninsured in all areas (8.7% in metro, 8.2% in non-metro, and 8.4% in noncore), a difference of only three-tenths of a percentage point between metro and noncore areas. In fact, this scenario reduces the percentage of uninsured by more than half in all areas [a decrease of 10.3 percentage points (from 19.0%) in metro, 10.8 percentage points (from 19.0%) in micro, and 11.5 percentage points (from 19.9%) in noncore].

Each level of ACA implementation reduces the percentage of uninsured in every area, with the greatest effect seen with Medicaid expansion in all states. While reductions in the uninsured are seen without Medicaid expansion, they are realized to a greater extent in urban areas (with estimated uninsured rates of 13.5% in metro, 14.1% in micro, and 14.5% in noncore). Under the current scenario, with only some of the states expanding Medicaid, 12.7% of residents in noncore counties and 11.9% in micropolitan counties are estimated to remain uninsured compared to 11.4% in metropolitan areas.

Figure 3: Estimated Percent of Non-elderly Uninsured by Rurality and Medicaid Expansion Status by Scenario



CONCLUSION

These data show that a nationwide Medicaid expansion would narrow the insurance coverage gap between rural and urban non-elderly adults; in fact, non-elderly adults living in micropolitan areas would have a higher rate of insurance coverage than metro residents. However, the variation in state implementation of Medicaid expansion (allowed by the Supreme Court ruling on Medicaid expansion) disproportionately affects rural populations, as fewer rural states have expanded Medicaid, and states with higher poverty in rural areas are least likely to expand. It is important to note that these are projected estimates. As Medicaid enrollment and household survey data become more widely available, it will be possible to verify these projections. Since October 2013, more than 4.8 million additional individuals have enrolled in Medicaid or the Children's Health Insurance Program (CHIP). Monthly enrollment has increased 8.2% over the monthly averages for July-September 2013; and among states that expanded Medicaid by March 2014, monthly enrollment increased by 12.9% compared to July-September 2013;[8] and thus far, eight million people have enrolled in private health insurance via the ACA market place.[9]

Our projected estimates are consistent with other analysis showing Medicaid could play a larger role for rural than urban uninsured populations.[10] If the coverage gap projected in this brief is accurate, it will be important to consider this discrepancy when considering national policy that may differentially affect rural populations and providers due to their state's expansion decision. As a continuation of this research, we are interviewing rural providers to gain their perspective on Medicaid expansion decisions and what effect those decisions may have on rural populations and the rural health care system.

METHODS

Insurance coverage estimates were triangulated from multiple data sources. First, we used the Small Area Health Insurance Estimates (SAHIE) for 2011 (U.S. Census) by income categories (< 200% FPL, 200-400% FPL, and > 400% FPL) by sex and age category (child versus adult). These estimates exist for all counties in the U.S. We then took state-level estimates created by the Urban Institute[11] and estimated the state uninsurance rates in each income-sex-age cell that aligned with the Urban Institute estimates, using 2011 (estimated) uninsurance rates. This was accomplished with repeated raking across each state cell until the SAHIE cell-specific rates aligned with the Urban Institute projections. We then repeated the rake at the county level to ensure that county-level cell-specific rates aligned with state-level aggregate estimates of insurance coverage. We used Tables 2, 3, and 6 from the Urban Institute report to triangulate the implied changes at the county level that were consistent with existing population and state-wide trends. This approach

provided estimates of the uninsurance rate for each county by sex, age category, and income category (although the uninsurance rate was assumed to be equal among boys and girls in the 18 and younger category).

Estimates of the percent of nonmetro residents living below 100% FPL were derived from the 2012 Small Area Income and Poverty Estimates (U.S. Census).

1. The ACA included a five percentage point deduction from Adjusted Gross Income in determining eligibility. Thus, although the stated eligibility is 133% FPL, the five percentage point deduction effectively makes it 138% FPL. See http://www.shadac.org/blog/aca-note-when-133-equals-138-fpl-calculations-in-affordable-care-act for more info.
2. As of June 2014, one more state (New Hampshire) decided to expand, bringing the number of expanding states to 27. The analysis here was conducted prior to that decision and thus classifies New Hampshire as a ”not expanding” state.
3. Status of State Action on the Medicaid Expansion Decision, 2014. Kaiser Family Foundation. Available at: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. Accessed March 22, 2014.
4. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. Kaiser Family Foundation, Apr 2014. Available at: http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/. Accessed May 22, 2014.
5. King J, Holmes M. Recent Changes in Health Insurance Coverage in Rural and Urban Areas. NC Rural Health Research & Policy Analysis Center, Findings Brief, May 2011. Available at: http://www.shepscenter.unc.edu/rural/pubs/finding_brief/FB100.pdf. Accessed May 22, 2014.
6. U.S. Department of Health and Human Services. Health Resources and Services Administration. Rural Health. Defining the Rural Population. Available at: http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html. Accessed May 28, 2014.
7. Bailey J. Medicaid Expansion as a Rural Issue: Rural and Urban States and the Expansion Decision. Center for Rural Affairs, Dec 2013. Available at: http://files.cfra.org/pdf/medicaid-expansion-a-rural-issue.pdf. Accessed May 28, 2014.
8. U.S. Department of Health and Human Services. Centers for Medicare and Medicaid Services. Medicaid & CHIP: March 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report, May 1, 2014. Available at: http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/March-2014-Enrollment-Report.pdf. Accessed May 28, 2014.
9. Kaiser Health News. Obama Sharply Criticizes Republicans As He Announces 8 Million Have Enrolled, Apr 17, 2014. Available at: http://www.kaiserhealthnews.org/Stories/2014/April/17/Obama-marketplace-enrollment-8-million.aspx. Accessed May 29, 2014.
10. Barker AR, Londeree JK, McBride TM, Kemper LM, Mueller K. The Uninsured: An Analysis by Age, Income, and Geography. RUPRI Center for Rural Health Policy Analysis, Feb 2014. Available at http://www.ruralhealthresearch.org/publications/913. Accessed June 18, 2014.
11. Buettgens M, Holahan J, Carroll C. Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid: Timely Analysis of Immediate Health Policy Issues. Urban Institute, March 2011. Available at: http://www.urban.org/uploadedpdf/412310-Health-Reform-Across-the-States.pdf. Accessed May 22, 2014.

This study was funded through Cooperative Agreement # U1CRH03714 with the Federal Office of Rural Health Policy (ORHP), Health Resources and Services Administration, U.S. Department of Health and Human Services. The conclusions and opinions expressed in this brief are the authors alone; no endorsement by the University of North Carolina, ORHP, or other sources of information is intended or should be inferred.