Changing Rural and Urban Enrollment in State Medicaid Programs

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Overview

- From October 2013—before implementation of the Affordable Care Act (ACA)—to November 2016, Medicaid enrollment grew by 27 percent.
- Little attention paid to date to how changes in Medicaid enrollment vary within states across geography
  - And how this been affected by ACA
- Project analyzes changes in enrollment in metropolitan, micropolitan, and rural (noncore) areas in both expansion states (those that used ACA funding to expand Medicaid coverage) and nonexpansion states (those that did not use ACA funding to expand Medicaid coverage).

Background

- ACA included funding for states to expand Medicaid up to 138 percent of the Federal Poverty Level (FPL)
  - However, in June 2012, the Supreme Court ruled mandatory Medicaid expansion unconstitutional, making Medicaid expansion optional to states.
  - A total of 25 states and the District of Columbia participating in the expansion at the start of 2014.
  - Two additional states expanded Medicaid in 2014, and three more states expanded in 2015, bringing the total to 29
  - Currently, 31 states and the District of Columbia have adopted Medicaid expansion, while 19 states have not.

Definitions

- In 2013, OMB defined **metropolitan** (metro) areas as broad labor-market areas that include:
  - Central counties with one or more urbanized areas; urbanized areas (described in the next section) are densely-settled urban entities with 50,000 or more people.
  - Outlying counties that are economically tied to the core counties as measured by labor-force commuting (if 25% of workers living in the county commute to the central counties, or if 25% of the employment in the county consists of workers coming out from the central counties—the so-called "reverse" commuting pattern).
- **Nonmetro counties** are outside the boundaries of metro areas and are further subdivided into two types:
  - **Micropolitan** (micro) areas, nonmetro labor-market areas centered on urban clusters of 10,000-49,999 persons and defined with the same criteria used to define metro areas.
  - **Rural (noncore)** counties, labeled "noncore" counties because they are not part of "core-based" metro or micro areas.

Background

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- Uneven patterns of Medicaid expansion at the state level may be exacerbating geographic coverage disparities.
  - In particular, there is concern about the disproportionately rural character of the states that have not expanded Medicaid:
    - Of the 15 states with the highest percentage of the population living in rural areas, only 9 (60 percent) have expanded Medicaid.
    - In contrast, of the 15 states with the highest percentage of the population living in urban areas, 13 (87 percent) have expanded Medicaid.
  - Also, existing disparities between rural and urban areas may narrow or widen due to expansion.
    - Rural residents have lower incomes; less likely to be covered by employer-sponsored health insurance; were more likely to be covered by public insurance.
    - In nonexpansion states, many uninsured left in coverage gap
      - In rural areas, 15% of uninsured left in a coverage gap, compared to only 9% in urban areas.
  - Also, are there differences in information and outreach, interest in ACA?

Changes in uninsured, 2013 to 2015

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By Location	Percent uninsured			Number of uninsured		
	2013	*2014*	*2015*	*2013*	*2014*	*2015*
	Percentage of population			Millions of persons		
All persons	13.3%	10.4%	9.1%	41.8	33.0	29.0
Living in:						
Metropolitan areas	13.4%	10.4%	9.0%	35.7	27.6	24.7
Nonmetropolitan areas	12.8%	10.7%	9.6%	6.1	5.4	4.3
	Percentage of population			Thousands of persons		
Missouri	13.0%	11.7%	9.8%	773	694	583

SOURCE: U.S. Bureau of the Census, 2016. "Health Insurance Coverage in the United States.

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Data and methods

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- County-level enrollment data were obtained either online or by request from the individual states' Medicaid offices, allowing analysis of changes in Medicaid enrollment by metropolitan status post-ACA.
  - Obtained Medicaid enrollment totals by county for 36 states—19 Medicaid expansion states and 17 nonexpansion states—for December 2012, which was immediately prior to expansion even by states that chose early adoption, and December 2015.
  - In several states, only monthly fiscal year averages, total enrollment counts for the whole year, or data from other months were available.
  - States with no rural (nonmicropolitan) counties (CT, DC, DE, NJ) were excluded from analyses.
- To control for seasonality of enrollment, we used December data whenever possible.
- Rural status was designated using the USDA Economic Research Service's 2013 Urban Influence Codes.

Key Findings

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- Medicaid growth rates vary by urban-rural status
  - In nonexpansion states enrollment growth twice as large in metropolitan counties, as compared to nonmetro counties from 2012 to 2015 (14 percent compared to 7 percent).
  - In contrast, in expansion states, the differential in growth rates between metropolitan, micropolitan, and rural counties much less dramatic in expansion states (growth rates of 43 percent, 38 percent, and 38 percent, respectively).
- Much variability at the state level
  - Even when controlling for expansion status
  - For example, some states with an above-average rural population, such as Tennessee and Idaho, had higher-than-average enrollment increases, with strong rural increases, while other states with similar proportions of rural residents, such as Nebraska, Oklahoma, Maine, and Wyoming, experienced enrollment decreases in micropolitan and/or rural counties.

Average county-level Medicaid enrollment growth, 2012-15

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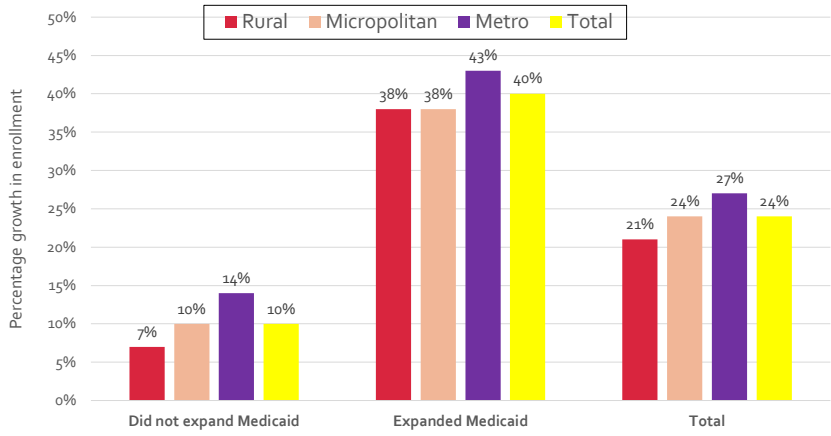

Key Findings

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- States' pre-ACA Medicaid eligibility levels for parents and children affected the potential for growth.
  - For example, some states that had higher eligibility levels (e.g., Maryland and Illinois) experienced lower Medicaid growth rates from 2012 to 2015, in part because their baseline enrollment was higher.
- In the expansion states with State-Based Marketplaces (SBMs) enrollment rate increases higher
  - For example, in Colorado and Nevada both have enrollment increases were over four times the overall average.

Results

- In general, Medicaid enrollment increases higher in urban areas, compared to micropolitan and rural areas
  - Proportional change greater in nonexpansion states
  - Great degree of variation across the U.S.
    - For example, decreases in enrollment in nonexpansion states ME, NE, OK, WY
    - Range of growth
      - 101% (CO), 97% (NV), 77% (CA) to -15% (ME), -6 (WY%), -1% (NE, OK)
- Enrollment growth may also have been impacted by a state's prior Medicaid eligibility levels for parents and children
  - For example: Illinois and Maryland, which had higher eligibility levels prior to 2014, experienced lower enrollment growth rates (16 percent and 19 percent, respectively)
  - Oregon and Kentucky, which had lower eligibility levels prior to the ACA, experienced above-average Medicaid growth rates (67 percent and 60 percent, respectively).
- Medicaid enrollment growth rates across metropolitan, micropolitan, and rural counties were also highest in states with SBMs.

Change in Medicaid Enrollment, 2012-2015, by state

Expansion states, as of December 2015

State (SBM)	% of Population that is Rural	Total % Change	Metro % Change	Micro % Change	Rural % Change	Pre-ACA Eligibility Cutoffs (%FPL) (Parents/Children)	% of Potential Population Enrolled in HIMs
VT	66%	34%	34%	33%	33%	191%/300%	46%
MT**	65%	43%	39%	30%	45%	54%/250%	48%
ND	51%	34%	27%	34%	35%	57%/160%	26%
IA	43%	26%	31%	25%	24%	80%/300%	20%
KY	42%	60%	69%	59%	55%	57%/200%	30%
AR	40%	9%	10%	8%	9%	16%/200%	24%
WV	39%	63%	67%	62%	61%	31%/300%	33%
NH	38%	43%	42%	42%	52%	47%/300%	50%
AK	33%	20%	14%	20%	21%	78%/175%	35%
MN	23%	38%	44%	43%	32%	215%/275%	22%
OH	21%	28%	33%	24%	22%	96%/200%	30%
MI	18%	20%	21%	20%	19%	64%/200%	43%
OR	17%	67%	66%	67%	70%	39%/300%	46%
CO	14%	101%	110%	123%	90%	106%/250%	22%
IL	12%	16%	16%	17%	15%	139%/300%	40%
PA	12%	26%	28%	22%	23%	58%/300%	46%
NV	10%	97%	109%	97%	89%	84%/200%	36%
WA	10%	54%	48%	54%	67%	71%/300%	27%
NY	7%	27%	31%	21%	25%	150%/400%	22%
AZ	5%	36%	37%	33%	38%	106%/175%	34%
MD	3%	19%	19%	16%	15%	122%/300%	34%
CA	2%	77%	77%	75%	78%	106%/250%	47%
Total	13%	40%	43%	38%	38%		37%

Change in Medicaid Enrollment, 2012-2015, by state

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Non-Expansion states, as of December 2015

State (SBM)	% of Population that is Rural	Total % Change	Metro % Change	Micro % Change	Rural % Change	Pre-ACA Eligibility Cutoffs (%FPL) (Parents/Children)	% of Potential Population Enrolled in HIMs
WY	70%	-6%	0%	3%	-12%	50%/200%	35%
MS	55%	11%	15%	11%	11%	29%/200%	26%
SD	54%	2%	9%	1%	2%	50%/200%	24%
ME	42%	-15%	-15%	-20%	-15%	133%/200%	58%
NE	37%	-1%	-2%	1%	-2%	58%/200%	36%
OK	36%	-1%	0%	-1%	-3%	51%/185%	31%
ID	35%	27%	24%	27%	28%	37%/185%	51%
KS	34%	9%	12%	8%	9%	31%/232%	31%
MO	26%	11%	13%	11%	9%	35%/300%	43%
AL	25%	11%	13%	9%	9%	23%/300%	33%
NC	23%	19%	23%	17%	16%	47%/200%	54%
TN	23%	21%	23%	21%	18%	122%/250%	37%
GA	18%	4%	8%	3%	1%	48%/235%	41%
LA	17%	19%	20%	19%	17%	24%/250%	38%
SC	17%	13%	16%	10%	7%	89%/200%	44%
TX	12%	12%	13%	9%	11%	25%/200%	35%
UT	11%	7%	8%	12%	4%	42%/200%	45%
FL	4%	17%	20%	16%	10%	56%/200%	58%
Total	19%	10%	14%	10%	7%		43%

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Change in Medicaid Enrollment by County

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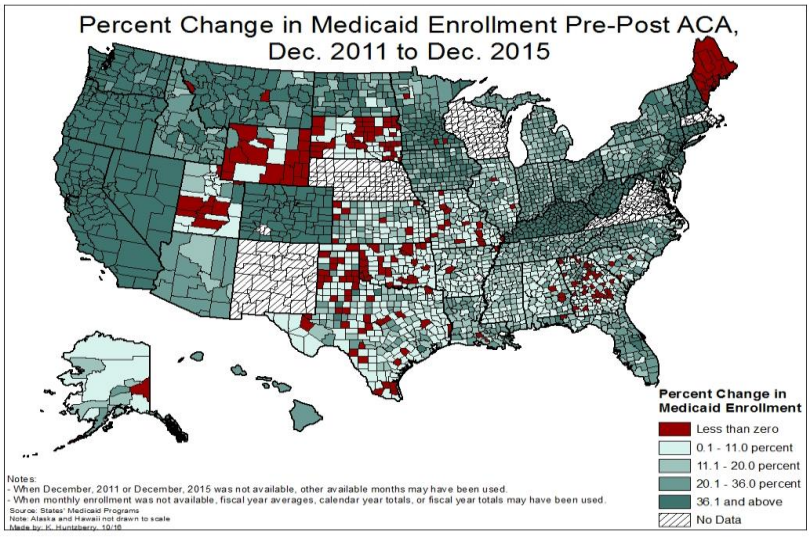

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Conclusions

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- Medicaid enrollment has increased rapidly in both expansion and nonexpansion states since the passage of the ACA.
  - Gains were larger in expansion states and in metropolitan areas
  - geographic differential more pronounced in nonexpansion states and in states without SBMs
  - This may exacerbate disparities in uninsurance rates
- Study is descriptive, and thus the causal reasons behind these changes are not established, some areas in particular need further exploration.
  - Potential reasons for low enrollment in rural populations in non-expansion states may include
    - limited outreach or lesser presence of ACA navigators in rural areas
    - less interest in or knowledge about seeking out ACA coverage on the part of parents (since children newly enrolled in Medicaid/CHIP as parents go through process)
    - backlogs in processing of Medicaid applications
    - bureaucratic roadblocks created by states to control costs, reduce woodwork effect.

Conclusions

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- Enrollment differences could also be a result of variations in HIM outreach efforts that have had spillover effects
  - Supported by higher enrollment changes in some SBMs (California, Colorado, Kentucky, Idaho, Oregon, and Washington).
- Differences in nonexpansion states may imply that the state is budget-conscious and may be less interested in Medicaid outreach.
  - Variations in outreach efforts between rural and urban areas within nonexpansion states may be due to the fact that most outreach in nonexpansion states is funded privately and charitably
- Socioeconomic differences between urban and rural areas (e.g., income, poverty) may also play a role.
- Further exploration and analysis is needed
  - Multivariate analysis, using difference-in-difference models.