

Rural Implications of Medicaid Expansion under the Affordable Care Act

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Introduction

In order for the Affordable Care Act (ACA) Medicaid expansion to effectively meet the needs of rural populations, implementation will need to be based on the underlying differences in rural and urban populations and on the unique needs of rural residents and health systems. Missing information that is critical to informing ACA implementation includes: the extent to which prior public health insurance expansions have covered rural populations; whether rural residents who are expected to be newly eligible for Medicaid in 2014 differ from their urban counterparts; the extent to which rural individuals might differentially benefit from the ACA Medicaid expansion in light of the expansion becoming optional; and whether rural enrollees are likely to have adequate access to primary care. This study addresses these knowledge gaps using the 2007-2011 panels of the Medical Expenditure Panel Survey (MEPS), linked with state-level Medicaid policy data and county-level primary care provider data.

Background

In the years preceding ACA implementation, state Medicaid and/or Children's Health Insurance Programs (CHIP) varied in the extent to which they included parents, the income levels at which parents were eligible, and the extent to which eligible parents enrolled. By 2011, 24 states covered parents through a combination of CHIP, Section 1115 Research & Demonstration waivers, and state-funded programs. More than 20 states also used waivers or state funds to cover non-disabled childless adults, although benefits varied among states, ranging from full Medicaid benefits to limited benefits to premium assistance programs for adults who met narrow criteria (Kaiser Commission on Medicaid and the Uninsured 2014). Among states without coverage expansions, access to Medicaid was often restricted to working parents with extremely low incomes (as little as 20% FPL) and typically excluded childless adults altogether (Rosenbaum 2009).

Shortly after passage of the ACA, policy experts began to help states plan for Medicaid expansion by estimating the likely cost of adding new adult enrollees. These studies were somewhat limited because they used current Medicaid enrollees to project costs (e.g., Natoli, Chech, & Verghese 2011) instead of using individuals who were eligible but not enrolled or individuals who would be newly

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eligible under the ACA eligibility expansions—two groups that could differ substantially from those who were already enrolled in Medicaid. Some experts have argued that the uninsured are generally healthier than Medicaid enrollees, so new enrollees' service use should be lower than for current Medicaid participants (Ku 2010). More recent studies confirmed the notion that potential eligibles are healthier than current Medicaid enrollees, yet rural-urban differences remain unknown (Chang & Davis 2013; Hill, Abdus, Hudson, & Selden 2014).

Previous studies have also not fully assessed the extent to which rural individuals might differentially benefit from the ACA Medicaid expansion in light of the expansion becoming optional. When the ACA was passed, rural health policy experts suggested that individuals living in rural areas were most likely to benefit from expansion given their generally lower incomes and higher uninsured rates (Coburn, Lundblad, MacKinney, McBride, & Mueller 2010; Lenardson, Ziller, Coburn, & Anderson 2009). However, with the Medicaid expansion becoming a state option, the impact on rural access to health insurance coverage is unclear.

Finally, while researchers have begun assessing state-level provider capacity to serve new enrollees, the adequacy of the rural provider supply has not been evaluated. Ku et al., document large differences in primary care capacity across states and speculate that inner cities and rural areas may be at high risk of poor provider availability (2011). However, the authors did not empirically test this assumption and, while they note that states with high uninsurance rates also have a lower primary care supply, they did not assess the extent to which rural communities may be affected.

Methods

This study examines the characteristics of low-income rural and urban adults potentially eligible for Medicaid under the ACA (i.e., those who were previously eligible but not enrolled and those who are newly eligible under the ACA Medicaid

expansion) by linking data from the 2007-2011 Medical Expenditure Panel Survey (MEPS) with state-level Medicaid policy data from the Kaiser Commission on Medicaid and the Uninsured and data on county-level primary care provider supply and safety net programs from the Area Resource File (ARF). The analysis was limited to non-elderly adults (ages 19 to 64) with incomes below 138 percent FPL who were U.S. born and did not have private insurance or Medicare. The resulting sample consisted of nearly 11,000 individuals, of whom roughly 2,200 (22%) lived in a rural area.

The analysis sought to (1) differentiate between current and potential Medicaid enrollees; (2) establish which potential enrollees lived in expansion versus non-expansion states; and (3) describe the characteristics of each enrollee group. Findings are based on bivariate statistical analyses, which assessed the differences between current and potential Medicaid enrollees by residence and between rural potential enrollees living in expansion versus non-expansion states.

Findings

Assuming Full Participation, Rural Residents Would Benefit More than Urban Residents from Medicaid Expansion

Prior to ACA implementation, rural adults with incomes below 138 percent FPL were somewhat more likely than their urban counterparts to be uninsured (45% versus 43%). As shown in Figure 1, this small difference was driven primarily by lower rates of Medicaid coverage among rural adults (21% versus 25% urban), since rural adults in this income group were slightly more likely than urban adults to have private insurance or Medicare.

These rural-urban differences in Medicaid coverage and uninsurance rates among low-income adults likely reflect state differences in Medicaid policy prior to the ACA. For example, during the study period we found that only 18 percent of low-income rural adults lived in states that had expanded

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Figure 1: Health Insurance Coverage Among Rural and Urban Non-Elderly Adults Below 138% FPL (2007-2011)

	Rural %	Urban %
Private Insurance	26.3	25.4
Medicaid	20.4	25.0
Medicare	8.0	6.4
Uninsured	45.3	43.2

Source: 2007-2011 Medical Expenditure Panel Survey (MEPS). Rural-urban difference significant at $p < .05$.

Medicaid to parents living at or above the poverty level, compared to 26 percent of low-income adults in urban areas. Among childless adults, there was no rural-urban difference in eligibility for Medicaid.

In addition to having slightly higher uninsurance rates among low-income adults, rural areas have a higher concentration of the uninsured living in the income range targeted by Medicaid expansion: 40 percent of uninsured adults in rural areas have

incomes below 138 percent FPL compared to only 34 percent of those in urban areas. Thus, if all states expanded Medicaid and all eligible adults enrolled, the reduction in uninsurance rates would be greater in rural than urban areas.

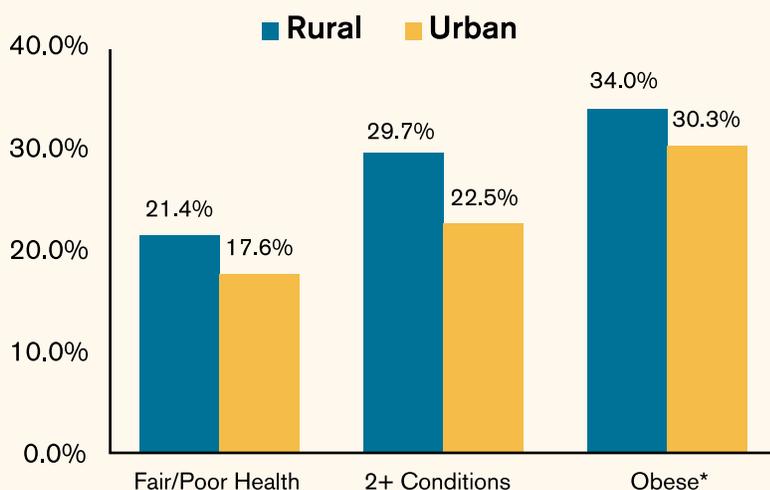
Uninsured Low-Income Adults Are Generally Healthier than their Medicaid-Covered Counterparts, but with Rural-Urban Differences

Recent studies examining differences between individuals enrolled in Medicaid and other low-income adults who are uninsured have found the uninsured to be generally healthier than those with Medicaid coverage (Chang & Davis 2013; Hill, Abdus, Hudson, & Selden 2014). The results of this analysis support these findings for both rural and urban adults. Generally speaking, the health status of potentially eligible individuals differs from that of currently Medicaid enrollees in several key ways. In both rural and urban areas, potential enrollees

- (1) report themselves to be in fair or poor health less often than current enrollees;
- (2) report fewer chronic health conditions than current enrollees;
- and (3) are less likely to be obese than current enrollees. Rural potential enrollees are less likely to smoke than current enrollees (47% versus 54%), but in urban areas smoking rates are the same for both current and potential enrollees (approximately 42%).

Although our analysis indicates that potential Medicaid enrollees are in better health than current enrollees, potential enrollees living in rural areas are older (23% are aged 50 years or older in rural areas versus 19% in urban areas) and are more likely to have health problems than their urban counterparts. For example, 21 percent of rural potential enrollees report

Figure 2: Rural-Urban Differences in Health Status of Potential Medicaid Enrollees



Source: 2007-2011 Medical Expenditure Panel Survey (MEPS). *Rural-urban differences in obesity rate significant at $p < 0.10$; other differences significant at $p < 0.05$

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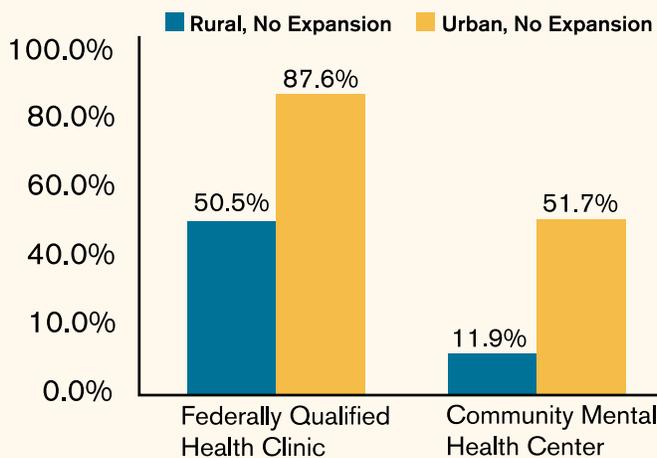
Figure 3: State Medicaid Expansion Status Among Rural and Urban Adults (19-64) with Incomes Below 138% FPL

	Rural %	Urban %
Expanding Medicaid	37.9	49.7
Alternative Model	4.4	1.6
Not Expanding Medicaid	43.8	35.2

Source: 2007-2011 Medical Expenditure Panel Survey (MEPS) and Kaiser Commission on Medicaid and the Uninsured; Kaiser Family Foundation 2014. Rural-urban difference significant at $p < .05$.

themselves to be in fair or poor health, compared to 18 percent of urban potential enrollees (Figure 2). Similarly, 30 percent of potential Medicaid enrollees in rural areas have two or more chronic health conditions, compared to only 23 percent of those in urban areas. Rural potential enrollees are also more likely to be obese than are urban potential enrollees (34% versus 30%).

Figure 4: Percent of Rural-Urban Uninsured in Non-Expansion States with Safety Net Providers in their County (Adults age 19-64,



Source: 2007-2011 Medical Expenditure Panel Survey (MEPS) and Kaiser Commission on Medicaid and the Uninsured; Kaiser Family Foundation 2014 and Area Resource File. Rural-urban difference significant at $p < .05$.

Rural Residents Are Less Likely to Live in States that are Expanding Medicaid

Although our findings suggest that low-income rural adults are more likely than their urban counterparts to benefit from full Medicaid expansion, our findings also suggest that the potential impact of the ACA is limited by the Supreme Court decision making the law's Medicaid expansion optional for states. While 50 percent of urban low-income adults live in a state that is expanding its Medicaid program (as of January 2014), only 38 percent of rural low-income adults do (Figure 3). About 44 percent of all low-income rural adults live in a state with no plans to expand coverage in any form, compared to 35 percent of low-income adults in urban areas. However, four percent of low-income adults in rural areas live in a state that has opted to expand coverage through an alternative to Medicaid (e.g., Indiana has a waiver to enroll its low-income uninsured in a program akin to a health savings plan), compared to 2 percent of low-income adults in urban areas.

Rural Uninsured in Non-Expansion States Have Lower Access to Safety Net Providers

Rural potential Medicaid enrollees have access to a smaller number of primary care providers per capita, irrespective of their state's decision to expand Medicaid. In expansion states, the average number of primary care providers per 100,000 rural residents is 49.6, compared to 79.9 for urban residents. In non-expansion states, there are 58.1 providers per 100,000 people in rural areas and 70.0 providers in urban areas. This finding suggests that rural uninsured individuals who gain Medicaid under the ACA might still have lower access to primary care than their urban counterparts.

Access to health care is likely to be an even greater problem for potential enrollees

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who live in rural areas in non-expansion states. Compared to their urban counterparts, the rural low-income uninsured are far less likely to live in a county with a formal safety net provider (Figure 4). These safety net providers have a mission to serve low-income populations regardless of their ability to pay and are a critical part of the health care infrastructure for both the uninsured and Medicaid enrollees. However, just 51 percent of individuals in rural areas have a federally qualified health center (FQHC) in their county, compared to 88 percent of individuals in urban areas. Similarly, only 12 percent of rural potential enrollees in non-expansion states have access to a community mental health center (CMHC), compared to 52 percent of their urban counterparts.

Conclusion

The findings from this study confirm that rural communities have much to gain from full Medicaid expansion under the ACA. Since their uninsured rates are higher than those in urban areas, and a greater concentration of their uninsured population falls within the ACA's targeted income range, rural communities stand to see disproportionate coverage gains under Medicaid expansion. However, as of January 2014, low-income rural adults are less likely than their urban counterparts to live in a state that is expanding Medicaid (Kaiser Family Foundation 2014). As a result, the opportunity to eliminate the rural-urban gap in insurance coverage is unlikely to be realized unless additional states choose to participate in the future.

At the same time, primary care resources are more limited for rural potential Medicaid enrollees, in both expansion and non-expansion states. This suggests the need for high-level health resource planning to ensure that rural communities can better meet the primary care needs of their populations. This is particularly true for rural communities in non-expansion states, where a large portion of the low-income uninsured lack access to providers such as FQHCs and CMHCs that have a formal

mission to serve underserved populations. Taken together, these findings suggest that the decision by some states to not expand Medicaid may increase disparities in access and uncompensated care burden for some rural populations and providers.

Suggested Citation

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