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

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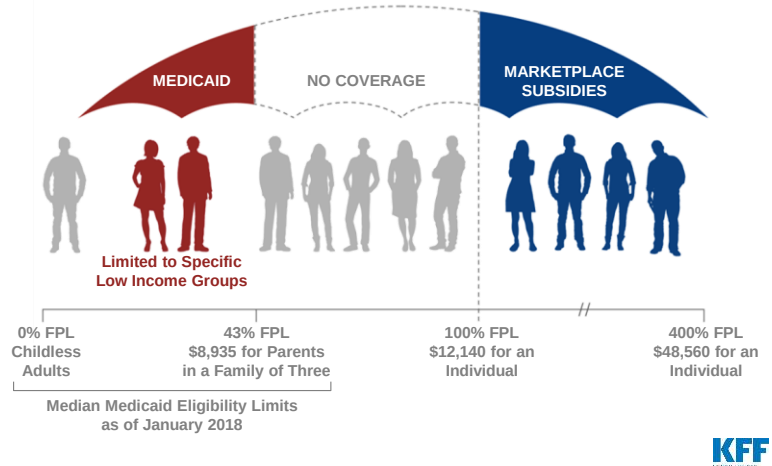
While millions of people have gained coverage through the expansion of Medicaid under the Affordable Care Act (ACA), state decisions not to implement the expansion leave many without an affordable coverage option. Under the ACA, Medicaid eligibility is extended to nearly all low-income individuals with incomes at or below 138 percent of poverty ($28,676 for a family of three in 2018[1]). 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 June 2018, 17 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 a year for a family of three in 2018, and in nearly all states not expanding, childless adults remain ineligible.[3] 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 fall into a "coverage gap" of having incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits (Figure 1).

Figure 1

Gap in Coverage for Adults in States that Do Not Expand Medicaid Under the ACA



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, describes who they are, 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 Methods box at the end of the report, and more detail is available in the Technical Appendices available here.

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

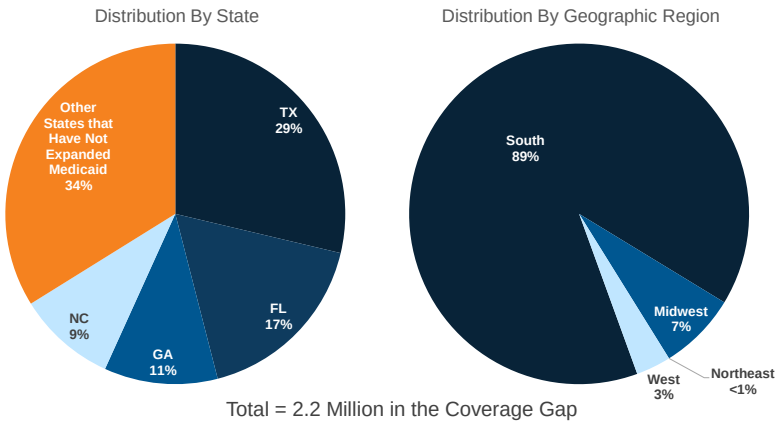
Nationally, more than two million[4] poor uninsured adults fall into the "coverage gap" that results from state decisions not to expand Medicaid, meaning their income is above current Medicaid eligibility but below the lower limit for Marketplace premium tax credits. These individuals would be eligible for Medicaid had their state chosen to expand coverage.

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. More than a quarter of people in the coverage gap reside in Texas, which has both a large uninsured population and very limited Medicaid eligibility (Figure 2). Seventeen 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 17) of states that opted not to expand Medicaid.[5] As a result, nearly nine in ten people in the coverage gap reside in the South (Figure 2).

Figure 2

Distribution of Adults in the Coverage Gap, by State and Region

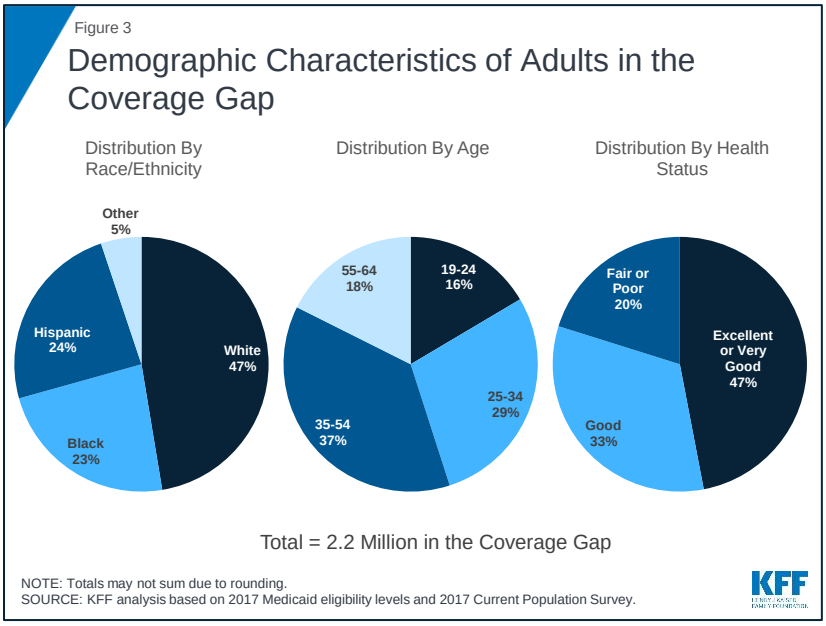


Total = 2.2 Million in the Coverage Gap

NOTE: Totals may not sum due to rounding.
SOURCE: KFF analysis based on 2017 Medicaid eligibility levels and 2017 Current Population Survey.

What Are the Characteristics of People in the Coverage Gap?

The characteristics of the population that falls into the coverage gap largely mirror those of poor uninsured adults. For example, because racial/ethnic minorities are more likely than White non-Hispanics to lack insurance coverage and are more likely to live in families with low incomes, they are disproportionately represented among poor uninsured adults and among people in the coverage gap. Nationally, 47% of uninsured adults in the coverage gap are White non-Hispanics, 24% are Hispanic, and 23% are Black (Figure 3). However, the race and ethnicity of people in the coverage gap also reflects differences in the racial/ethnic composition between states that have and have not expanded Medicaid. Several states that have large Black populations (e.g., Florida, Georgia, and Texas) have not expanded Medicaid under the ACA. As a result, Blacks account for a slightly higher share of people in the coverage gap compared to the total poor adult uninsured population. The racial/ethnic characteristics of the population in the coverage gap vary widely by state, mirroring the underlying characteristics of the state population (Table 1).



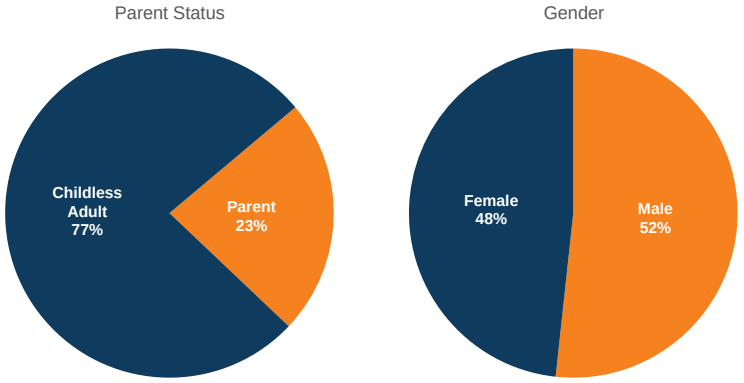
Nonelderly adults of all ages fall into the coverage gap (Figure 3). Notably, over half are middle-aged (age 35 to 54) or near elderly (age 55 to 64). Adults of these ages are likely to have increasing health needs, and research has demonstrated that uninsured people in this age range may leave health needs untreated until they become eligible for Medicare at age 65.[6]

While nearly half (47%) of people in the coverage gap report that their health is excellent or very good, one fifth (20%) report that they are in fair or poor health (Figure 3). These individuals have known health problems that likely require medical attention. Studies repeatedly demonstrate that uninsured people are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.[7] When they do seek care, the uninsured often face unaffordable medical bills.[8]

The characteristics of people in the coverage gap also reflect Medicaid program rules in states not expanding their programs. Because non-disabled adults without dependent children are ineligible for Medicaid coverage in most states not expanding Medicaid, regardless of their income, adults without dependent children account for a disproportionate share of people in the coverage gap (77%) (Figure 4). Still, nearly a quarter (23%) of people in the coverage gap are poor parents whose income places them above Medicaid eligibility levels. About 161,000 uninsured children have a parent in the coverage gap (data not shown). Research has found that parent coverage in public programs is associated with higher enrollment of eligible children,[9] so these children may be hard to reach if their parents continue to be ineligible for coverage. The share of people in the coverage gap who are adults without dependent children (versus parents) varies by state (see Table 1) due to variation in current state eligibility. For example, Tennessee covers all parents up to at least poverty, so all people in the coverage gap in that state are adults without dependent children.

Figure 4

Parent Status and Gender of Adults in the Coverage Gap



Total = 2.2 Million in the Coverage Gap

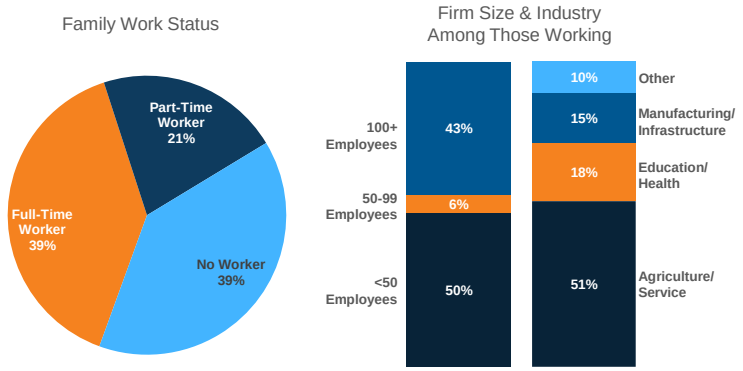
NOTE: Totals may not sum due to rounding.
SOURCE: KFF analysis based on 2017 Medicaid eligibility levels and 2017 Current Population Survey.

Even though women are more likely than men to qualify for Medicaid in states not expanding their programs, women account for about the same share (48%) of adults in the coverage gap (Figure 4). This pattern occurs because women make up the majority of poor adults in states not expanding their programs.

The work status of people in the coverage gap indicates that there are limited coverage options available for people in this situation. Six in ten people in the coverage gap are in a family with a worker, and about half are working themselves (Figure 5). The vast majority of workers in the coverage gap do not have an offer of coverage through their

Figure 5

Work Status of Adults in the Coverage Gap



Total = 2.2 Million in the Coverage Gap

Total = 1.1 Million Workers in the Coverage Gap

NOTE: Industry classifications: Agriculture/Service includes agriculture, construction, leisure and hospitality services, wholesale and retail trade. Education/Health includes education and health services. Professional/Public Admin includes finance, professional and business services, information, and public administration. Manufacturing/Infrastructure includes mining, manufacturing, utilities, and transportation. Totals may not sum to 100% due to rounding.
SOURCE: KFF analysis based on 2017 Medicaid eligibility levels and 2017 Current Population Survey.

employer (data not shown), and half work for small firms (<50 employees) that are not subject to ACA penalties for not offering coverage. Further, many firms do not offer coverage to part-time workers. A majority of workers in the coverage gap also work in industries with historically low insurance rates, such as the agriculture and service industries.

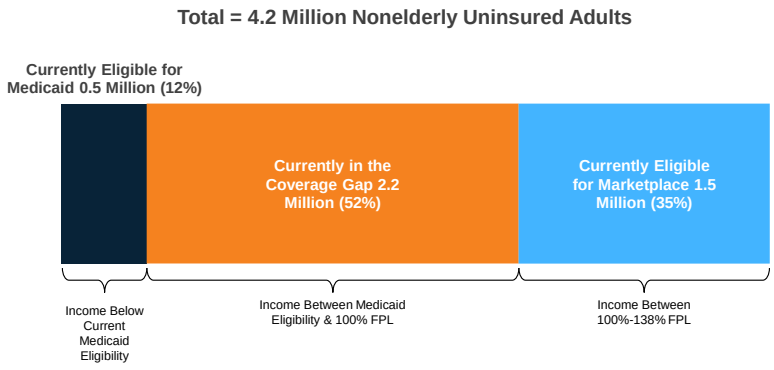
Four in ten adults in the coverage gap are in a family with no workers. Since the Medicaid expansion was designed to reach those left out of the employer-based system, and because people in the coverage gap by definition are poor, it is not surprising that most are unlikely to have access to health coverage through a job.

What Would Happen if All States Expanded Medicaid?

If states that are currently not expanding their programs adopt the Medicaid expansion, all of the 2.2 million adults in the coverage gap would gain Medicaid eligibility. In addition, 1.5 million uninsured adults who are currently eligible for Marketplace coverage (those with incomes between 100 and 138% of poverty[10]) would also gain Medicaid eligibility (Figure 6 and Table 2). Though most of these adults are eligible for tax credits to purchase Marketplace coverage,[11] Medicaid coverage may provide lower premiums or cost-sharing than they would face under Marketplace coverage.

Figure 6

Nonelderly Uninsured Adults in Non-Expansion States Who Would Be Eligible for Medicaid if Their States Expanded



NOTE: Total may not sum to 100% due to rounding. 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.
SOURCE: KFF analysis based on 2017 Medicaid eligibility levels and 2017 Current Population Survey.

A small number (about 512,000) 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 4.2 million people in the seventeen current non-expansion states. The potential scope of Medicaid varies by state (Table 2).

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.

The majority of people in the coverage gap are in poor working families—that is, either they or a family member is employed but still living below the poverty line. Given the characteristics of their employment, it is likely that many will continue to lack access to coverage through their job even with ACA provisions for employer responsibility for coverage.[13] Further, even if they do receive an offer from their employer that meets ACA requirements, many will find their share of the cost to be unaffordable. Because this population is generally exempt from the individual mandate, and because firms will not face a penalty for these workers remaining uninsured, 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 without financial assistance: in 2018, the national average unsubsidized premium for a 40-year-old non-smoking individual purchasing coverage through the Marketplace was $456 per month for the lowest-cost silver plan and $339 per month for a bronze plan,[14] which equates to more than seventy 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.

Further, the racial and ethnic composition of the population that falls into the coverage gap indicates that state decisions not to expand their programs disproportionately affect people of color, particularly Black Americans. 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. In addition, the 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, several

non-expansion states have reported that consideration of the Medicaid expansion is on hold due to uncertainty about the future of the ACA.[15] 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.

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Table 1: Number and Characteristics of Poor Uninsured Nonelderly Adults in the ACA Coverage Gap by State, 2016					
State	**Number in Coverage Gap**	**Share in the Coverage Gap Who Are:**			
		People of Color	**Adults Without Dependent Children**	**Female**	**In a Working Family**
All States Not Expanding Medicaid	2,223,000	53%	77%	48%	61%
Alabama	75,000	49%	79%	57%	50%
Florida	384,000	47%	87%	49%	48%
Georgia	240,000	60%	78%	54%	62%
Idaho	22,000	N/A	80%	51%	69%
Kansas	48,000	42%	84%	36%	46%
Mississippi	99,000	54%	79%	44%	59%
Missouri	87,000	N/A	63%	44%	82%
Nebraska	16,000	N/A	77%	40%	52%
North Carolina	208,000	36%	79%	43%	60%
Oklahoma	84,000	51%	76%	42%	53%
South Carolina	92,000	47%	91%	51%	54%
South Dakota	15,000	51%	67%	N/A	76%
Tennessee	163,000	31%	N/A	39%	41%
Texas	638,000	74%	63%	53%	74%
Utah	46,000	N/A	77%	39%	77%
Wisconsin*	0	-	-	-	-
Wyoming	6,000	N/A	93%	59%	48%

NOTES: * Wisconsin provides Medicaid eligibility to adults up to the poverty level under a Medicaid waiver. As a result, there is no one in the coverage gap in Wisconsin. Totals may not sum due to rounding. N/A: Sample size too small for reliable estimate.
SOURCE: KFF analysis based on 2017 Medicaid eligibility levels and 2017 Current Population Survey.

Table 2: Uninsured Adults in Non-Expansion States Who Would Be Eligible for Medicaid if Their States Expanded by Current Eligibility for Coverage, 2016				
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	4,236,000	512,000	2,223,000	1,502,000
Alabama	153,000	N/A	75,000	59,000
Florida	702,000	40,000	384,000	278,000
Georgia	463,000	75,000	240,000	148,000
Idaho	43,000	N/A	22,000	19,000
Kansas	79,000	N/A	48,000	26,000
Mississippi	167,000	N/A	99,000	57,000
Missouri	199,000	N/A	87,000	86,000
Nebraska	34,000	N/A	16,000	15,000
North Carolina	339,000	46,000	208,000	85,000
Oklahoma	142,000	N/A	84,000	40,000
South Carolina	170,000	N/A	92,000	61,000
South Dakota	29,000	N/A	15,000	12,000
Tennessee	332,000	61,000	163,000	108,000
Texas	1,178,000	101,000	638,000	439,000
Utah	91,000	N/A	46,000	31,000
Wisconsin*	97000	65,000	0	32,000
Wyoming	15,000	N/A	6,000	6,000

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 2017 Medicaid eligibility levels and 2017 Current Population Survey.

Methods

This analysis uses data from the 2017 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). The CPS ASEC provides socioeconomic and demographic information for the United Sates population and specific subpopulations. Importantly, the CPS ASEC 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. For this analysis, we 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 Medicaid and Marketplace households and count income, see the detailed technical Appendix A available here.

Undocumented immigrants are ineligible for federally-funded Medicaid and Marketplace coverage. Since CPS 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.[16,17] 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 CPS, 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 available here.

Individuals in tax-filing units with access to an affordable offer of Employer-Sponsored Insurance are still potentially MAGI-eligible for Medicaid coverage, but they are ineligible for advance premium tax credits in the Health Insurance Exchanges. Since CPS data indicate whether a worker held an offer of ESI at the time of interview (for the 2017 CPS, February, March, or April 2017) but not during the prior year (which serves as our basis for type of insurance coverage), we developed a model that predicts offer of ESI for any individuals with a change in employment status across the period. 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 available here.

The CPS asks respondents about coverage at the time of the interview as well as throughout the preceding calendar year. People who report any type of coverage throughout the preceding calendar year are counted as “insured.” Thus, the calendar year measure of the uninsured population captures people who lacked coverage for the entirety of 2016 (and thus were uninsured at the start of 2017). We use this measure of insurance coverage in 2016, rather than the measure of coverage at the time of interview, because the latter lacks detail about coverage type that is used in our model.

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, 2017, updated to reflect state Medicaid expansion decisions as of October 2017 and 2016 Federal Poverty Levels.[18] 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.[19]

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.

Endnotes

1 U.S. Department of Health and Human Services, Office of The Assistant Secretary for Planning and Evaluation, 2018 Poverty Guidelines. Available at: https://aspe.hhs.gov/poverty-guidelines

2 Maine adopted the Medicaid expansion through a ballot initiative in November 2017 and the ballot measure requires submission of a state plan amendment (SPA) within 90 days and implementation of expansion within 180 days of the measure's effective date; however, the Governor failed to meet the SPA submission deadline (April 3, 2018). Due to the adoption of Medicaid expansion by ballot, Maine is categorized as an expansion state in this analysis, but, as of June 2018, expansion has not been implemented.

3 Of the states not moving forward with the expansion, only Wisconsin provides full Medicaid coverage to adults without dependent children as of 2014. 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/

4 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.

5 Stephens, J., S. Artiga, and J. Paradise. Health Coverage and Care in the South in 2014 and Beyond. (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured), April 2014, available at: http://kff.org/report-section/health-coverage-and-care-in-the-south-in-2014-and-beyond-health-coverage-and-care-in-the-south-today/

6 McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. "Use of Health Services by Previously Uninsured Medicare Beneficiaries." New England Journal of Medicine. 2007 July 12, 357(2): 143-53.

7 For a review of findings on access to care for the uninsured, see: Kaiser Commission on Medicaid and the Uninsured. The Uninsured: A Primer. (Washington, DC: Kaiser Family Foundation. Available at: http://kff.org/uninsured/report/the-uninsured-a-primer/

8 Ibid.

9 Sommers BD. "Insuring children or insuring families: do parental and sibling coverage lead to improved retention of children in Medicaid and CHIP?" J Health Econ. 2006 Nov;25(6):1154-69. Epub 2006 Jun 5.

10 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.

11 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.

12 Antonisse, L., Garfield R., Rudowitz R. and Artiga S. 2017 The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review. (Washington, DC: Kaiser Family Foundation), available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/

13 See http://www.kff.org/infographic/employer-responsibility-under-the-affordable-care-act/ for a review of these requirements.

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 Gifford, K., Ellis, E., Edwards, B.C., et al. 2017. Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018.(Washington, DC: Kaiser Family Foundation), available at: https://www.kff.org/medicaid/report/medicaid-moving-ahead-in-uncertain-times-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2017-and-2018/

16 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

17 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.

18 Based on state-reported eligibility levels as of January 1, 2017. Eligibility levels are updated to reflect state implementation of the Medicaid expansion as of October 2017 and 2016 Federal Poverty Levels but may not reflect other eligibility policy changes since January 2017. 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 2017: Findings from a 50-State Survey, (Washington, DC: Kaiser Family Foundation, January 12, 2017), Available at: https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-findings-from-a-50-state-survey

19 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 CPS 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