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Closing Medicaid Coverage Gap Would Help Diverse Groups and Reduce Inequities

By Gideon Lukens and Laura Harker

More than 1.6 million uninsured adults are stuck in the Medicaid "coverage gap," with no path to affordable health coverage. They have incomes below the federal poverty level (FPL) — too low to qualify for financial help in the Affordable Care Act (ACA) marketplaces — yet they don't qualify for Medicaid because they live in one of the ten states that have not adopted the ACA Medicaid expansion. People in the coverage gap are racially and ethnically diverse, and 65 percent are people of color. Closing the coverage gap would therefore shrink ethnic and racial disparities in health coverage, which the ACA has significantly reduced but not eliminated.

Adults in the coverage gap range from ages 19 to 64 and include working families and parents caring for children. Compared to other adults, they are more likely to have disabilities. Among workers, adults in the coverage gap are more likely to be self-employed or to work in industries such as construction, retail, and food services, where wages tend to be low and employers are less likely to offer health coverage. Adults in the coverage gap are also more likely to be employed in caregiving occupations such as child care workers, home health aides, personal care aides, and nursing assistants.

The ACA extended Medicaid coverage to adults with incomes up to 138 percent of the FPL ($20,783 for an individual in 2024), and it provided subsidized marketplace coverage to those with higher incomes. However, the Supreme Court allowed states to choose whether to expand Medicaid. This has created a coverage gap for people with incomes below 100 percent of the FPL ($15,060 for an individual in 2024) in states that haven't expanded because marketplace subsidies are only available to people with incomes over the FPL.[1] In the median non-expansion state, Medicaid eligibility for parents is 35 percent of the FPL, or just $9,037 in annual income for a family of three.[2] And adults without children are generally ineligible for Medicaid in these states no matter how low their incomes are.

[1] For state-level estimates, see Appendix tables and CBPP, "The Medicaid Coverage Gap: State Fact Sheets," updated April 3, 2024, https://www.cbpp.org/research/health/the-medicaid-coverage-gap.

[2] KFF, "State Health Facts: Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level," January 1, 2023, https://www.kff.org/affordable-care-act/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/. Medicaid eligibility thresholds are as of January 2023; dollar amounts shown here reflect 2024 poverty guidelines determined by the Department of Health and Human Services.

A large body of evidence demonstrates the benefits of Medicaid expansion for people's health and financial well-being as well as for state budgets and health care providers.[3] Several states have expanded Medicaid in recent years, and several more are considering expansion. For states that refuse to adopt expansion, Congress should close the coverage gap by extending coverage to individuals with low incomes in those states — as proposed, for example, in Senator Warnock's Bridge to Medicaid Act, Representative Fletcher's ACCESS Act, and President Biden's 2025 budget.[4]

In addition to closing the coverage gap, Congress should aid other individuals with low and moderate incomes by making permanent the premium tax credit improvements for ACA marketplace coverage, which were established in 2021 and are scheduled to expire after 2025. This would enable people with incomes above 100 percent of the FPL to avoid out-of-pocket premium spikes and continue to access affordable coverage.[5]

The Coverage Gap Exacerbates Racial and Ethnic Inequities

After the ACA's major coverage expansions took effect in 2014, uninsured rates fell across racial and ethnic groups, and coverage disparities narrowed. But the coverage gap has contributed to persistent inequities in health coverage. People of color make up 65 percent of people in the coverage gap, compared to 43 percent of people in the United States as a whole. Black and Latino people are particularly likely to be in the coverage gap, composing 24 and 35 percent of the coverage gap, respectively, compared to 12 and 19 percent of all people in the U.S.[6] (See Figure 1.)

[3] Laura Harker and Breanna Sharer, "Medicaid Expansion: Frequently Asked Questions," CBPP, updated June 14, 2024, https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions-0; Madeline Guth, Rachel Garfield, and Robin Rudowitz, "The Effects of Medicaid Expansion Under the ACA: Studies from January 2014 to January 2020," KFF, March 17, 2020, https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/.

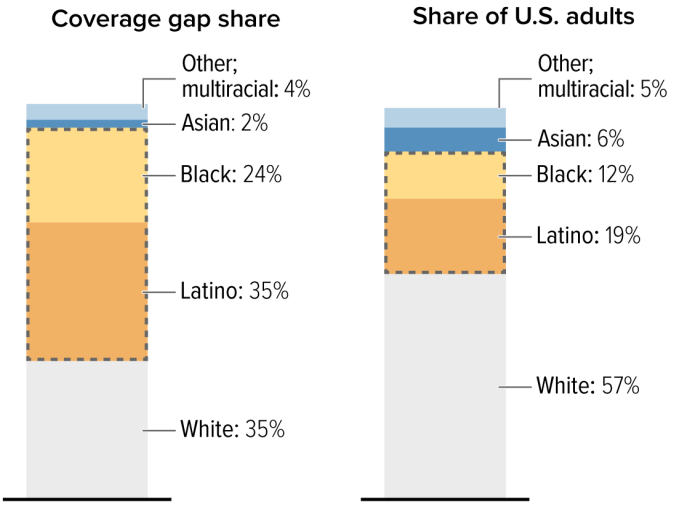
[4] S. 4684 – Bridge to Medicaid Act of 2024, https://www.congress.gov/bill/118th-congress/senate-bill/4684?s=4&r=45; H.R. 3004 – Affordable Care Coverage Expansion and Support Act, https://www.congress.gov/bill/118th-congress/house-bill/3004. Department of Health and Human Services, "Fiscal Year 2025 Budget in Brief," March 2024, https://www.hhs.gov/about/budget/fy2025/index.html#bib;

[5] Claire Heyison, Jennifer Sullivan, and Sarah Lueck, "Building on the Affordable Care Act: Strategies to Address Marketplace Enrollees' Cost Challenges," CBPP, April 10, 2024, https://www.cbpp.org/research/health/building-on-the-affordable-care-act-strategies-to-address-marketplace-enrollees; Gideon Lukens, "Health Insurance Costs Will Rise Steeply if Premium Tax Credit Improvements Expire," CBPP, June 4, 2024, https://www.cbpp.org/research/health/health-insurance-costs-will-rise-steeply-if-premium-tax-credit-improvements-expire.

[6] In this report, all comparisons of the coverage gap population to the overall U.S. population refer to those aged 19-64, the age range of people who are in the coverage gap.

FIGURE 1

Black, Latino People Are Overrepresented in Medicaid Coverage Gap



Note: Estimates are for people aged 19-64. Latino people include people of any race who identify as Hispanic, Latino, or Spanish origin. Other categories include only people who identify as a single race and not Latino.

Source: CBPP analysis of 2022 American Community Survey

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A major reason for these disparities is that states with relatively large shares of Black and Latino populations, particularly states in the South, are less likely to have expanded Medicaid. Some 38 and 33 percent of Black and Latino people, respectively, reside in non-expansion states, compared to 26 percent of the overall U.S. population. (See Figure 2.) Texas alone, where roughly 1 in 5 Latino people in the U.S. live, is home to 74 percent of Latino people in the coverage gap.

Black and Latino people are also more likely to have incomes below the federal poverty level and to be uninsured. These factors are closely connected to structural racism, which reduces their access to employer health coverage and, evidence suggests, contributes to state decisions over whether to expand Medicaid.[7]

The large majority of American Indian and Alaska Native (AIAN) people identify as multiple races and ethnicities.[8] Roughly 4,000 people in the coverage gap are AIAN when defined as single race alone. But the number of AIAN people in the coverage gap increases more than tenfold, to 45,000, when those who identify as AIAN plus one or more other race or ethnicity are also included.

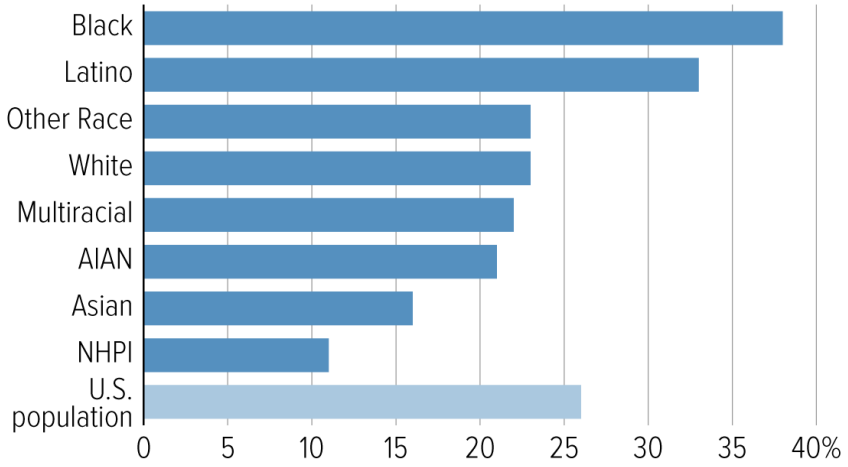
[7] Ruqaiijah Yearby, Brietta Clark, and José Figueroa, "Structural Racism in Historical and Modern US Health Care Policy," *Health Affairs*, February 2022, https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01466; Colleen Grogan and Sunggeun (Ethan) Park, "The Racial Divide in State Medicaid Expansions," *Journal of Health Politics, Policy and Law*, June 2017, https://read.dukeupress.edu/jhppl/article/42/3/539/13927/The-Racial-Divide-in-State-Medicaid-Expansions.

[8] Robert Maxim, Gabriel R. Sanchez, and Kimberly R. Huyser, "Why the federal government needs to change how it collects data on Native Americans," Brookings Institution, March 30, 2023, https://www.brookings.edu/articles/why-the-federal-government-needs-to-change-how-it-collects-data-on-native-americans/.

FIGURE 2

Share Residing in Non-Expansion States Varies Widely Among Racial and Ethnic Groups

Share of group living in state with no Medicaid expansion



Note: AIAN = American Indian and Alaska Native. NHPI = Native Hawaiian and Pacific Islander. Estimates are for people aged 19-64. Latino people include people of any race who identify as Hispanic, Latino, or Spanish origin. AIAN include people who identify as AIAN alone or in combination with other races and ethnicities. Other categories include only people who identify as a single race and not Latino.

Source: CBPP analysis of 2022 American Community Survey

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Coverage Gap Worsens Disparities *Within* Racial and Ethnic Groups

Research increasingly emphasizes the importance of disaggregating racial and ethnic categories to understand and address the drivers of inequities in health coverage.[9] Estimates of what shares of specific racial and ethnic groups are in the coverage gap are subject to more uncertainty than are tabulations of existing data such as uninsured rates, but examining the disaggregated data can still provide useful context.[10]

For example, we estimate that Cuban people are overrepresented in the coverage gap relative to their share of the Latino population, even though they have a lower uninsured rate and a smaller

[9] Breanna Sharer and Gideon Lukens, "Health Coverage Rates Vary Widely Across — and Within — Racial and Ethnic Groups," CBPP, May 9, 2024, https://www.cbpp.org/research/health/health-coverage-rates-vary-widely-across-and-within-racial-and-ethnic-groups.

[10] See Appendix II for an overview of how the coverage gap is estimated. Estimates of the coverage gap by specific racial and ethnic groups are particularly sensitive to the imputation of immigration status because people without a lawful immigration status are generally not eligible to enroll in Medicaid or the ACA marketplace, and Medicaid has strict requirements that bar many people who have lawful immigration statuses from enrolling. For specific racial and ethnic groups, this paper therefore does not provide numeric estimates; instead, it presents qualitative examples that illustrate how the coverage gap contributes to disparities within broader racial and ethnic categories.

share under the poverty level than other Latino groups.[11] This can partly be traced to the history of Cuban immigration to the U.S., which included several waves of large-scale migration following the Cuban Revolution to nearby Florida, a state that has not yet expanded Medicaid.[12] Seventy-three percent of Cuban people in the U.S. reside in non-expansion states, far more than the 33 percent of all Latino people and the 26 percent of all people living in those states. (See Figure 3.) Thus, federal legislation closing the coverage gap — or a decision by Florida to expand Medicaid — would particularly benefit Cuban people in this country.

Among Asian groups in the U.S., Vietnamese people are overrepresented in the coverage gap, in part because 26 percent live in non-expansion states, compared to 16 percent of all Asian people. Vietnamese migration spiked in 1975 as refugees sought safety following the U.S. military withdrawal from Vietnam and the end of the Vietnam War; the Vietnamese immigrant population increased rapidly in the 1980s and 1990s, with growth slowing in recent decades.[13] While California is the most common state of residence for Vietnamese people, a much greater share of Vietnamese people than other Asian groups live in Texas, which has not expanded Medicaid. In addition, a relatively high share of Vietnamese people in the U.S. have incomes below the poverty level, and Vietnamese people have a high rate of self-employment, which precludes access to employer coverage.[14]

[11] CBPP analysis of the 2022 American Community Survey.

[12] Jorge Duany, "Cuban Migration: A Postrevolution Exodus Ebbs and Flows," Migration Policy Institute, July 6, 2017, https://www.migrationpolicy.org/article/cuban-migration-postrevolution-exodus-ebbs-and-flows.

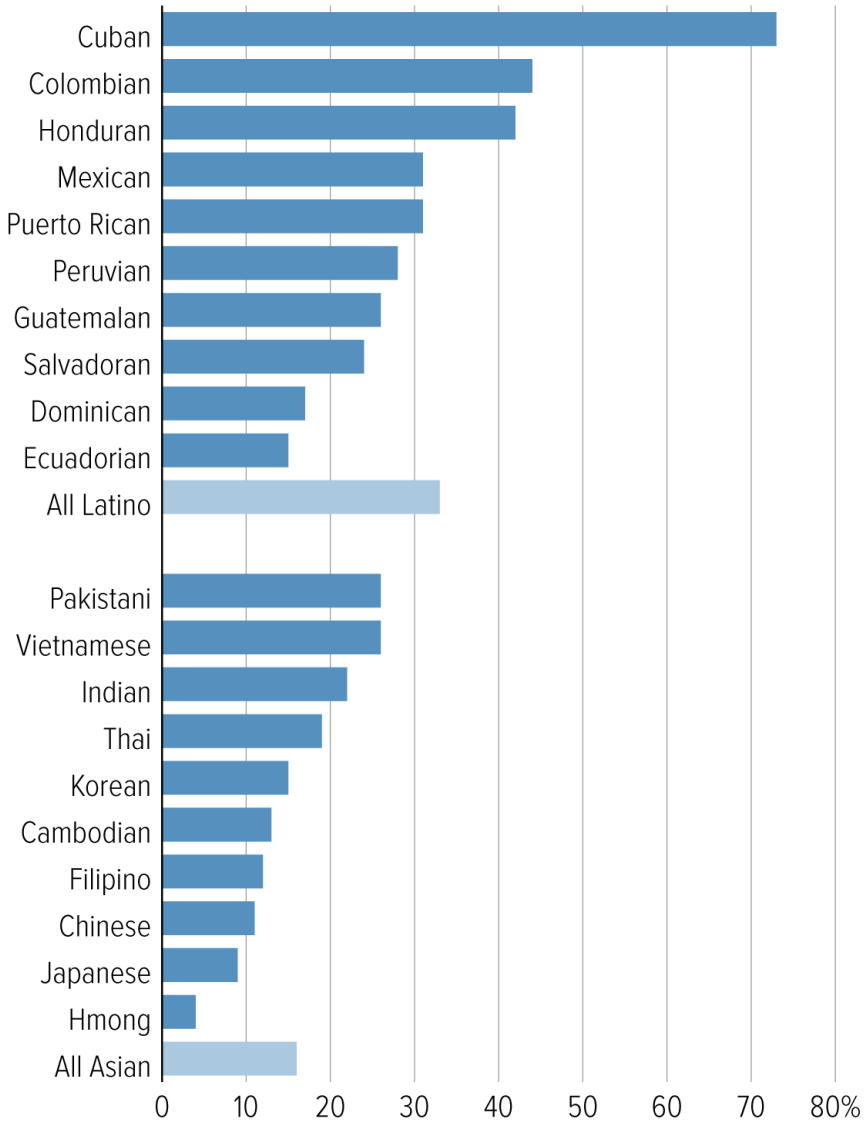
[13] Jeanne Batalova, "Vietnamese Immigrants in the United States," Migration Policy Institute, October 11, 2023, https://www.migrationpolicy.org/article/vietnamese-immigrants-united-states/.

[14] CBPP analysis of the 2022 American Community Survey.

FIGURE 3

Share Residing in Non-Expansion States Varies Widely Within Racial and Ethnic Groups

Share of group living in state with no Medicaid expansion



Note: Latino people include people of any race who identify as Hispanic, Latino, or Spanish origin. Asian people include only people who identify as a single race and not Latino.

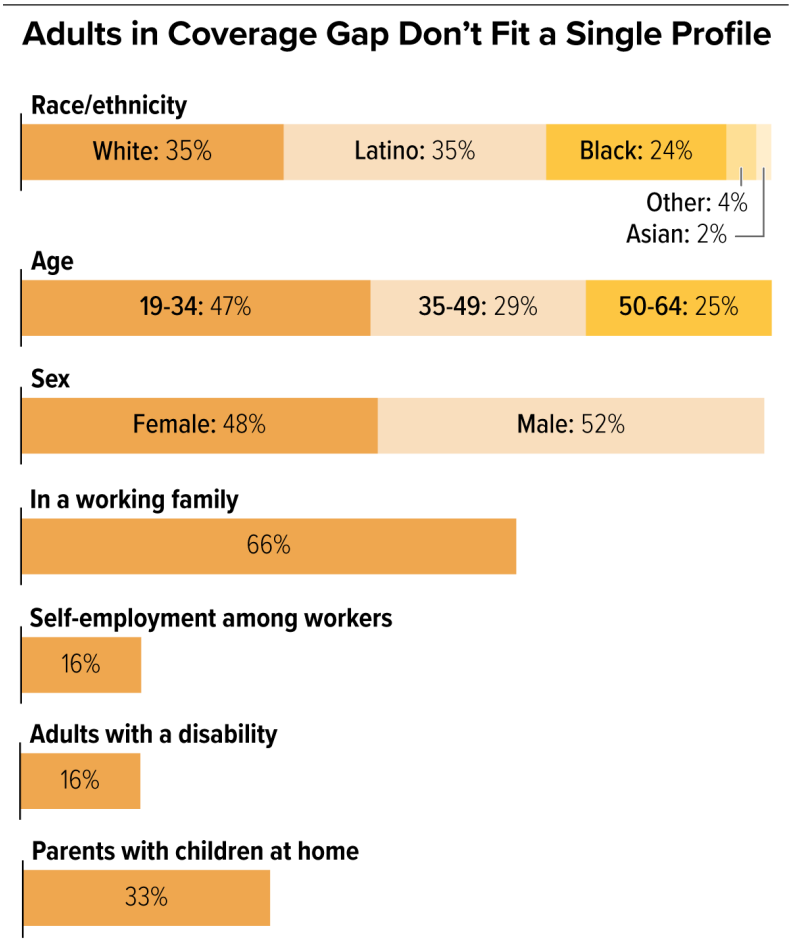
Source: CBPP analysis of 2022 American Community Survey

Most in Coverage Gap Work, Care for Children, or Have Disabilities

The large majority of adults in the coverage gap work, care for children at home, or have a disability.

Workers. Approximately two-thirds of adults in the coverage gap are in a family with at least one worker. (See Figure 4.) Working adults in the coverage gap are disproportionately likely to be self-employed and thus to lack access to coverage through an employer. About 16 percent of working adults in the coverage gap are employed in their own business, professional practice, or farm, compared to 9 percent of other working adults.[15]

FIGURE 4



Note: Estimates are for uninsured people aged 19-64, in non-institutional settings, not including the population without a documented immigration status in the U.S. Latino category includes people of any race. Other categories include only people who identify as single race and not Latino. Self-employment is measured as the share among people who are employed who report being self-employed in their own business, professional practice, or farm.

Source: CBPP analysis of 2022 American Community Survey

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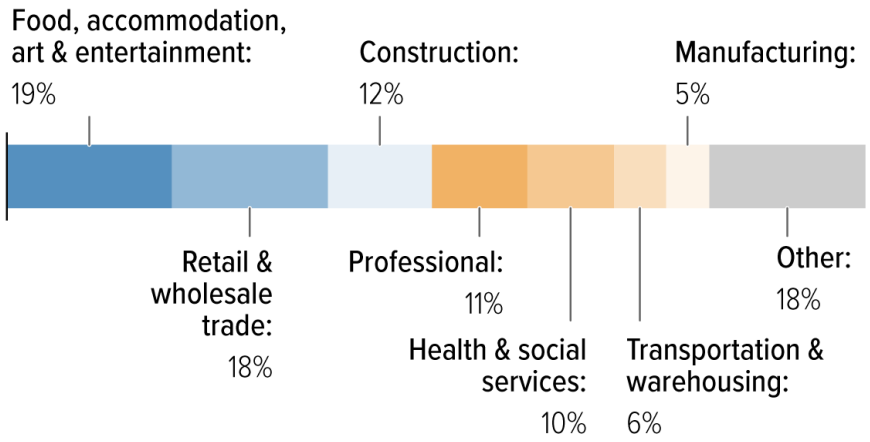
[15] *Ibid.*

By definition, adults in the coverage gap have incomes below the poverty level. Their jobs tend to have low wages and are concentrated in the industries least likely to offer health coverage.[16] (See Figure 5.) Among workers, 12 percent of coverage gap adults are employed in construction, compared to 8 percent of other adults. About 18 percent work in retail and wholesale trade, compared to 13 percent of other adults. Nineteen percent work in food, accommodation, and art and entertainment (such as employees of restaurants, hotels, performing arts companies, and amusement parks), more than double the share (8 percent) of other adults.[17] Meanwhile, coverage gap adults are disproportionately *less* likely to work in manufacturing and public administration, the two industries with the highest rates of employers offering coverage.

FIGURE 5

Workers in Coverage Gap Heavily Represented in Industries Less Likely to Offer Health Insurance



Source: CBPP analysis of 2022 American Community Survey

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Among workers, adults in the coverage gap are more than twice as likely as other adults to be employed in caregiving occupations. More than 5 percent of working adults in the coverage gap, or 42,000 people, are employed as child care workers, home health aides, personal care aides, and nursing assistants.

Parents. Roughly one-third of adults in the coverage gap are parents with children at home, and among these parents, one-third have a child under age 5. Research shows that extending coverage to parents through Medicaid expansion increases children's coverage and access to health care and improves families' financial security.[18]

[16] KFF, "2023 Employer Health Benefits Survey," October 18, 2023, https://www.kff.org/report-section/ehbs-2023-section-2-health-benefits-offer-rates/.

[17] CBPP analysis of the 2022 American Community Survey.

[18] Julie Hudson and Asako S. Moriya, "Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects on Their Children," *Health Affairs*, September 2017,

People with disabilities. Medicaid expansion provides an important pathway to coverage for people with disabilities. Generally, receiving Supplemental Security Income (SSI) automatically qualifies someone for Medicaid, but due to SSI's strict eligibility criteria, 7 in 10 non-elderly adults with disabilities who have Medicaid coverage obtain it through a different pathway.[19] Medicaid expansion allows people with disabilities to obtain coverage based on their income without having to meet SSI disability standards. Research indicates that Medicaid expansion increases employment among people with disabilities because they can maintain coverage while working and earning more income than SSI standards permit.[20]

We estimate that roughly 16 percent of adults in the coverage gap, or 269,000 people, have disabilities, compared to 11 percent of other adults.[21] Roughly half of this group, or 8 percent of coverage gap adults, have a serious cognitive disability; 6 percent of coverage gap adults have difficulty with basic physical activities such as walking, climbing stairs, carrying, or reaching.

Closing the Coverage Gap Would Benefit Individuals, States, Providers

Extensive research finds that Medicaid expansion helps people become healthier and more financially secure, while improving access to care and shrinking long-standing racial inequities in coverage. Furthermore, the enhanced federal dollars from expansion have allowed states to see savings in their budgets and allowed health care providers to increase their operating margins and reduce their uncompensated care burdens.

Medicaid Expansion Improves Access to Care, Health Outcomes, Financial Well-Being

States that expanded Medicaid have seen significantly greater reductions in uninsured rates than states that failed to expand. In expansion states, the uninsured rate among low-income, non-elderly adults fell by more than half between 2013 and 2022, from 35 percent to 15 percent. In non-expansion states, it dropped only modestly, from 44 percent to 30 percent, leaving it twice the rate as in expansion states.[22]

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https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0347?journalCode=hlthaff; Maya Venkataramani *et al.,* "Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services," *Pediatrics*, December 2017, https://pediatrics.aappublications.org/content/140/6/e20170953; Jessica Schubel, "Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children," CBPP, updated June 14, 2021, https://www.cbpp.org/research/health/expanding-medicaid-for-parents-improves-coverage-and-health-for-both-parents-and.

[19] CBPP analysis of the 2022 American Community Survey. The estimate reflects people aged 19-64 who have a disability but do not receive SSI, and are enrolled in Medicaid but not dually enrolled in Medicare.

[20] Jean P. Hall *et al.*, "Effect of Medicaid Expansion on Workforce Participation for People With Disabilities," *American Journal of Public Health*, February 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5227925/.

[21] CBPP analysis of the 2022 American Community Survey.

[22] CBPP analysis of 2013 and 2022 American Community Survey data. Low income is defined as income under 200 percent of the FPL. The Medicaid continuous coverage requirement, in place from March 2020 to April 2023, prevented people from being disenrolled from Medicaid, leading to record low uninsured rates in 2022. However, the results would be similar using data from years prior to the pandemic. For example, between 2013 and 2019, the uninsured rate fell from 35 to 17 percent in expansion states and from 43 to 34 percent in non-expansion states.

Medicaid expansion states also narrowed racial and ethnic disparities in health coverage more than non-expansion states. Between 2013 and 2022, the gap in uninsured rates between white and Black adults under age 65 shrank by 67 percent in expansion states, versus 47 percent in non-expansion states. The gap between white and Latino adults shrank by 48 percent in expansion states, versus 30 percent in non-expansion states.[23]

People who receive health coverage through Medicaid expansion report having greater access to primary and preventive care and being less likely to forgo care. In expansion states, people without dependent children who could be in the coverage gap if their state had not expanded were 6.7 percentage points more likely than those in non-expansion states to have had a mammogram, and 6.1 percentage points more likely to take medication if diagnosed with high blood pressure.[24] In addition to greater access to care, people who gained expansion coverage experienced better health outcomes. Medicaid expansion saved the lives of at least 19,200 adults aged 55-64 in the first four years of the program and has been linked to improved cancer outcomes in young adults.[25]

Multiple studies also show that Medicaid expansion protects enrollees from catastrophic out-of-pocket medical costs and improves their overall financial well-being. Between 2013 and 2020, new medical debt dropped by 34 percentage points more in states that expanded Medicaid in 2014 than in states that did not expand Medicaid over this period.[26] People who gained coverage as a result of Medicaid expansion had about $1,140 less in overall unpaid debt sent to third-party collections.[27] And enrollees in Virginia's Medicaid expansion program reported decreased worry about paying for housing, food, monthly bills, and minimum loan payments one year after enrolling.[28]

Medicaid Expansion Brings Financial Benefits to States, Health Care Providers

The federal government pays 90 percent of the costs of expansion coverage, and adopting Medicaid expansion typically results in little to no net costs for state budgets due to offsetting

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[23] CBPP analysis of 2013 and 2022 American Community Survey data. The Black and white categories include individuals classified as a single race, not Latino. The Latino category can include people who identify as any race.

[24] Sherry Glied and Mark Weiss, "Impact of the Medicaid Coverage Gap: Comparing States That Have and Have Not Expanded Eligibility," Commonwealth Fund, September 11, 2023, https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/impact-medicaid-coverage-gap-comparing-states-have-and-have-not.

[25] Sarah Miller *et al.,* "Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data," *Quarterly Journal of Economics*, January 30, 2021, https://academic.oup.com/qje/article-abstract/136/3/1783/6124639?redirectedFrom=fulltext; Xu Ji *et al.,* "Survival in Young Adults With Cancer Is Associated With Medicaid Expansion Through the Affordable Care Act," *Journal of Clinical Oncology*, April 1, 2023, https://pubmed.ncbi.nlm.nih.gov/36525612/.

[26] Raymond Kluender *et al.,* "Medical Debt in the US, 2009-2020," *JAMA*, July 20, 2021, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8293024.

[27] Luojia Hu *et al., "*The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing," *Journal of Public Economics*, July 2018, https://pubmed.ncbi.nlm.nih.gov/30393411/.

[28] Hannah Shadowen, "Virginia Medicaid Expansion: New Members Report Reduced Financial Concerns During The COVID-19 Pandemic," *Health Affairs*, July 20, 2022, https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01910.

savings and revenue increases.[29] Expansion reduces spending on other areas of state budgets, like corrections and treatment programs for mental health and substance use, as well as state spending on some enrollees in existing Medicaid groups who can now attain coverage with a higher federal match through Medicaid expansion. And states with taxes on managed care plans and providers that serve Medicaid enrollees have generated higher revenue from those taxes due to enrollment increases.[30]

The remaining non-expansion states can obtain even more financial benefits from expansion through an incentive in the 2021 American Rescue Plan. States that expand Medicaid after March 2021 receive a two-year, five-percentage-point increase in their federal matching rate for traditional Medicaid enrollees. This would bring a combined $13.1 billion in federal funding to the ten remaining non-expansion states.[31]

Hospitals also benefit financially from Medicaid expansion, including through a reduction in their uncompensated care costs and improvements in operating margins and overall revenue.[32] By strengthening the financial position of health care providers, expansion helps them avoid cutting services or closing their doors. Hospitals in expansion states are about 84 percent less likely to close than hospitals in non-expansion states.[33] The risk of hospital closures is especially high in rural areas of the country.

Reducing the likelihood of a rural hospital closures, in turn, not only preserves health care access for people in the communities they serve, but also preserves local jobs and prevents more strain from falling on surrounding hospitals.[34]

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[29] Bryce Ward, "The Impact of Medicaid Expansion on States' Budgets," Commonwealth Fund, May 5, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets.

[30] Jesse Cross-Call, "Medicaid Expansion Continues to Benefit State Budgets, Contrary to Critics' Claims," CBPP, October 9, 2018, https://www.cbpp.org/research/health/medicaid-expansion-continues-to-benefit-state-budgets-contrary-to-critics-claims.

[31] Harker and Sharer, *op cit.*

[32] David Dranove, Craig Garthwaite, and Christopher Ody, "The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal," Commonwealth Fund, May 2017, https://www.commonwealthfund.org/publications/issue-briefs/2017/may/impact-acas-medicaid-expansion-hospitals-uncompensated-care; Fredric Blavin and Christal Ramos, "Medicaid Expansion: Effects on Hospital Finances and Implications for Hospitals Facing COVID-19 Challenges," *Health Affairs*, January 2021, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00502.

[33] Richard C. Lindrooth *et al.,* "Understanding The Relationship Between Medicaid Expansions And Hospital Closures," *Health Affairs*, January 2018, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0976.

[34] American Hospital Association, "Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care," February 2019, https://www.aha.org/system/files/2019-02/rural-report-2019.pdf; Shayann Ramedani, Daniel George, and Douglas Leslie, "The Bystander Effect: Impact of Rural Hospital Closures on the Operations and Financial Well-Being of Surrounding Healthcare Institutions," *Journal of Hospital Medicine*, September 2022, https://shmpublications.onlinelibrary.wiley.com/doi/abs/10.1002/jhm.12961.

Appendix I: Characteristics of Uninsured Adults in the Coverage Gap

APPENDIX TABLE 1

Uninsured Adults in the Coverage Gap, by Sex and Age, 2022

State	Total	Female	Male	19 to 34	35 to 49	50 to 64
Total, non-expansion states	1,653,000	797,000	856,000	772,000	475,000	406,000
Alabama	107,000	54,000	54,000	45,000	33,000	29,000
Florida	315,000	146,000	170,000	138,000	87,000	91,000
Georgia	192,000	97,000	95,000	91,000	54,000	47,000
Kansas	42,000	17,000	25,000	21,000	12,000	10,000
Mississippi	81,000	37,000	44,000	39,000	24,000	18,000
South Carolina	83,000	39,000	44,000	33,000	24,000	27,000
Tennessee	95,000	37,000	58,000	40,000	20,000	36,000
Texas	726,000	367,000	360,000	360,000	220,000	146,000
Wyoming	11,000	4,000	7,000	5,000	*	*

* Reliable estimates are not available due to small sample size.
Note: Estimates are for uninsured people aged 19-64, in non-institutional settings, not including the population without a documented immigration status in the U.S. See Appendix II for more details.
Source: CBPP estimates based on the 2022 American Community Survey

APPENDIX TABLE 2

Uninsured Adults in the Coverage Gap, by Race/Ethnicity, 2022

State	Total	Asian	Black	Latino	Other/multiracial	White
Total, non-expansion states	1,653,000	31,000	402,000	571,000	71,000	578,000
Alabama	107,000	*	43,000	7,000	5,000	52,000
Florida	315,000	6,000	73,000	96,000	17,000	124,000
Georgia	192,000	*	76,000	27,000	11,000	74,000
Kansas	42,000	*	*	9,000	*	25,000
Mississippi	81,000	*	45,000	*	*	30,000
South Carolina	83,000	*	34,000	5,000	3,000	40,000
Tennessee	95,000	*	23,000	4,000	6,000	61,000
Texas	726,000	17,000	103,000	421,000	21,000	164,000
Wyoming	11,000	*	*	*	*	8,000

* Reliable estimates are not available due to small sample size.
Note: Estimates are for uninsured people aged 19-64, in non-institutional settings, not including the population without a documented immigration status in the U.S. Latino category includes people of any race. Other categories include only people who identify as single race and not Latino. See Appendix II for more details.
Source: CBPP estimates based on the 2022 American Community Survey

APPENDIX TABLE 3

Uninsured Adults in the Coverage Gap, by Work, Family, Disability Status, 2022

State	In working families	Self-employed	Parent caregivers	Adults with disabilities
Total, non-expansion states	1,095,000	127,000	546,000	269,000
Alabama	59,000	6,000	32,000	25,000
Florida	204,000	25,000	92,000	50,000
Georgia	123,000	12,000	56,000	30,000
Kansas	29,000	*	12,000	9,000
Mississippi	44,000	5,000	21,000	16,000
South Carolina	47,000	5,000	13,000	18,000
Tennessee	51,000	7,000	10,000	21,000
Texas	530,000	62,000	307,000	97,000
Wyoming	7,000	*	3,000	*

* Reliable estimates are not available due to small sample size.
Note: Estimates are for uninsured people aged 19-64, in non-institutional settings, not including the population without a documented immigration status in the U.S. See Appendix II for more details.
Source: CBPP estimates based on the 2022 American Community Survey

Appendix II: Data and Methods

We use the Census Bureau's 2022 American Community Survey (ACS), combined with state Medicaid eligibility rules, to estimate the coverage gap population in the ten states that have not enacted the ACA's Medicaid expansion.[35] The coverage gap population is defined as uninsured adults aged 19-64 whose incomes are below the federal poverty level and who are ineligible for Medicaid because their states did not adopt the expansion. This includes parents whose incomes are above the eligibility limits for parents with children, and childless adults who wouldn't be eligible at any income level.

Medicaid and the marketplace have different rules for defining income and family units for the purposes of gaining coverage. These categories of income and family units (known as "health insurance units," or HIUs) are not directly available in the ACS data and must be estimated. To assess income eligibility, we group individuals into two types of HIUs: Medicaid HIUs and marketplace HIUs. For each type of HIU, we apply each program's rules for counting modified adjusted gross income for the purposes of eligibility. Our methodology for grouping into HIUs and counting income is based on ACS data and assumptions regarding family relationships, household composition, and tax filing rules and behavior.

Our coverage gap estimates do not include populations that are already eligible for Medicaid or would not be eligible even if their states expanded. For example, we impute immigration status and do not include the estimated population without a lawful immigration status in our coverage gap estimates because under existing rules, this group would not gain Medicaid eligibility if their states adopted the expansion.

We define people as having a disability if they meet at least one of the six categories as defined by the Census Bureau: blind or with serious difficulty seeing; deaf or with serious difficulty hearing, serious cognitive difficulty, ambulatory difficulty (difficulty with a basic physical activity such as walking or reaching), difficulty with self-care such as dressing or bathing, or difficulty doing basic activities outside the home alone.

[35] Although it is a non-expansion state, Wisconsin extends Medicaid eligibility to adults up to 100 percent of the poverty level through a waiver. Therefore, Wisconsin has no coverage gap population.