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Trends in State Medicaid Programs' Eligibility, Enrollment Rules and Benefits

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Recommended Citation

Fox, A.M., Feng, W.,* Zeitlin, J., Howell, E. (2020). "Trends in State Medicaid Programs' Eligibility, Enrollment Rules and Benefits," *Health Affairs*, 39(11): 1909–1916. <https://doi.org/10.1377/hlthaff.2019.01350>

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DOI: 10.1377/hlthaff.2019.01350
 HEALTH AFFAIRS 39,
 NO. 11 (2020): –
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 Foundation, Inc.

DATAWATCH

Trends In State Medicaid Eligibility, Enrollment Rules, And Benefits

Recent literature has focused on the impact of the differential adoption by states of the Affordable Care Act’s Medicaid expansion. However, additional Medicaid policy dimensions exist where state-level trends in coverage have varied, including eligibility, benefits, and administrative burden, both before and after implementation of the Affordable Care Act.

It is estimated that from 2014 to 2016 as many as 14.5 million people became insured through Medicaid and the Children’s Health Insurance Program (CHIP) as a consequence of the Medicaid expansion that was adopted as part of the Affordable Care Act (ACA) in 2010.¹ Medicaid covered 20 percent of the US population in 2018.² Many

more people would have been insured if all states had undertaken the Medicaid expansion. However, although states’ decisions about whether to expand Medicaid have received extensive attention,³ fewer studies have measured and reported on other ways that Medicaid generosity varies across states (including in their eligibility policy criteria for other categorical groups, re-

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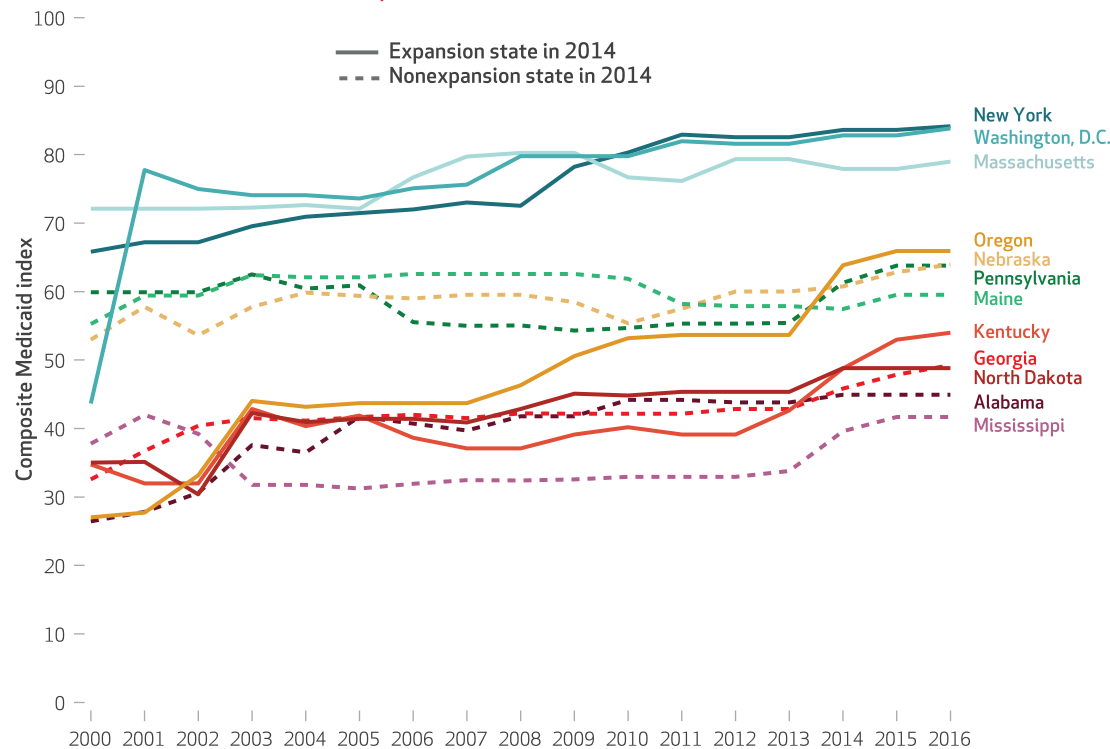
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EXHIBIT 1

Trends in the composite Medicaid index, 2000–16



SOURCE Authors’ analysis of data from the Kaiser Family Foundation’s 50-state survey of Medicaid and Children’s Health Insurance Program eligibility, enrollment, and cost-sharing policies and Medicaid benefits database. **NOTES** The composite Medicaid index for the highest- and lowest-value expansion and nonexpansion states. The composite index was measured as an average of the four subindices (income eligibility, administrative burden reduction, benefits and copays, and immigrant eligibility). To ensure data coverage over the full period, benefit levels were assumed to be constant at 2003 levels from 2000 to 2003 and at 2012 levels from 2013 to 2016.

duction of barriers to enrollment, and benefit comprehensiveness), many of which predate the ACA.⁴⁻⁷ This study provides a broader picture of state Medicaid programs beyond Medicaid expansion by comprehensively measuring state Medicaid policy across four dimensions over the period from 2000 to 2016–18 (exhibit 1).

Before the ACA's Medicaid expansion, Medicaid eligibility was primarily constrained to low-income parents, pregnant women, and children (each with varying income eligibility thresholds), as well as certain elderly or disabled people. The Medicaid expansion constituted a substantial shift in eligibility by untethering income eligibility from categorical criteria and enabling low-income adults without dependents to access the program. However, in addition to eligibility thresholds for adults without dependents, Medicaid programs vary widely in the income thresholds that regulate eligibility across various low-income categories (parents, pregnant women, and children), as well as whether and to what extent the programs allow noncitizens to join—whether lawful permanent residents or migrants

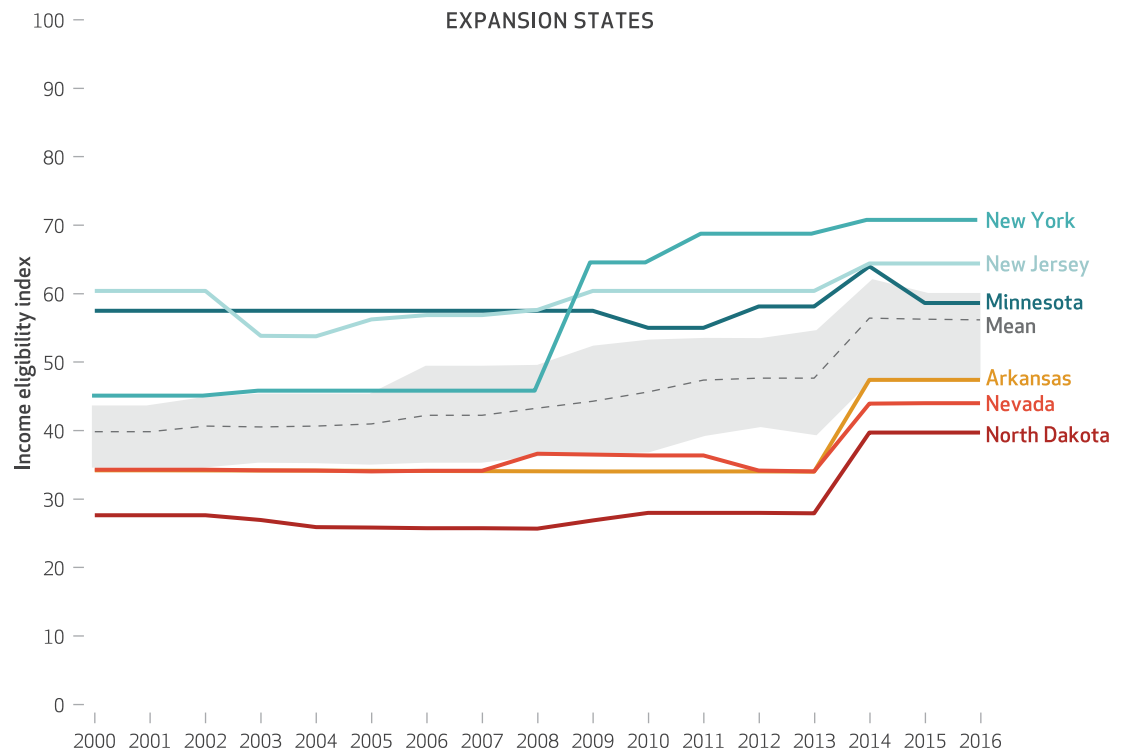
without legal status. Moreover, states vary in terms of the enrollment and renewal rules they impose. In addition, states differ in terms of the benefits they cover. Although federal law requires certain core benefits to be covered, such as hospital and physician services, other benefits are optional for states, including dental and optometry services, among others, and whether copays are required for these services. As a consequence, individuals' experiences of Medicaid can diverge dramatically across states.⁴

In spite of these variations, few studies or existing data sources have attempted to comprehensively summarize state Medicaid policies across these different dimensions and over time.⁴⁻⁷ The objectives of this study were to generate a longitudinal index of state Medicaid policies along four dimensions across all fifty states and Washington, D.C., to share with the broader research community and enable comparisons of trends across both expansion and nonexpansion states.

By systematically documenting differences in program implementation across the states, we

EXHIBIT 2

Trends in the income eligibility index in expansion states, 2000–16



SOURCE Authors' analysis of data from the Kaiser Family Foundation's 50-state survey of Medicaid and Children's Health Insurance Program eligibility, enrollment, and cost-sharing policies. **NOTES** The income eligibility index was measured as the average income eligibility thresholds across categorical eligibility groups divided by 400 percent of the federal poverty level (the maximum value across categorical eligibility groups). The three states with the highest and lowest values on average during the period examined are identified. Data are directly observed for all years except 2007 (2006 data were used for 2007) and 2001 (data from 2000 were used for 2001). The twenty-fifth and seventy-fifth percentiles are indicated by the shaded area.

aim to provide researchers, policy makers, and the public with a fuller image of how states vary in their Medicaid programs beyond whether or not the state has expanded Medicaid to adults without dependents.

Study Data And Methods

Data from the Kaiser Family Foundation’s website were compiled into a longitudinal data set. The Kaiser Family Foundation has collected detailed information on eligibility, enrollment, renewal, benefits, and cost-sharing policies through its fifty-state survey (plus Washington, D.C.) of state Medicaid and CHIP programs since 2000 and has published annual reports on the findings.⁸ The reports are based on a telephone survey of state Medicaid and CHIP officials conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families. We also drew on data collected by the Urban Institute on Medicaid access among lawful permanent residents and unauthorized immigrants.⁹ Information on each state policy

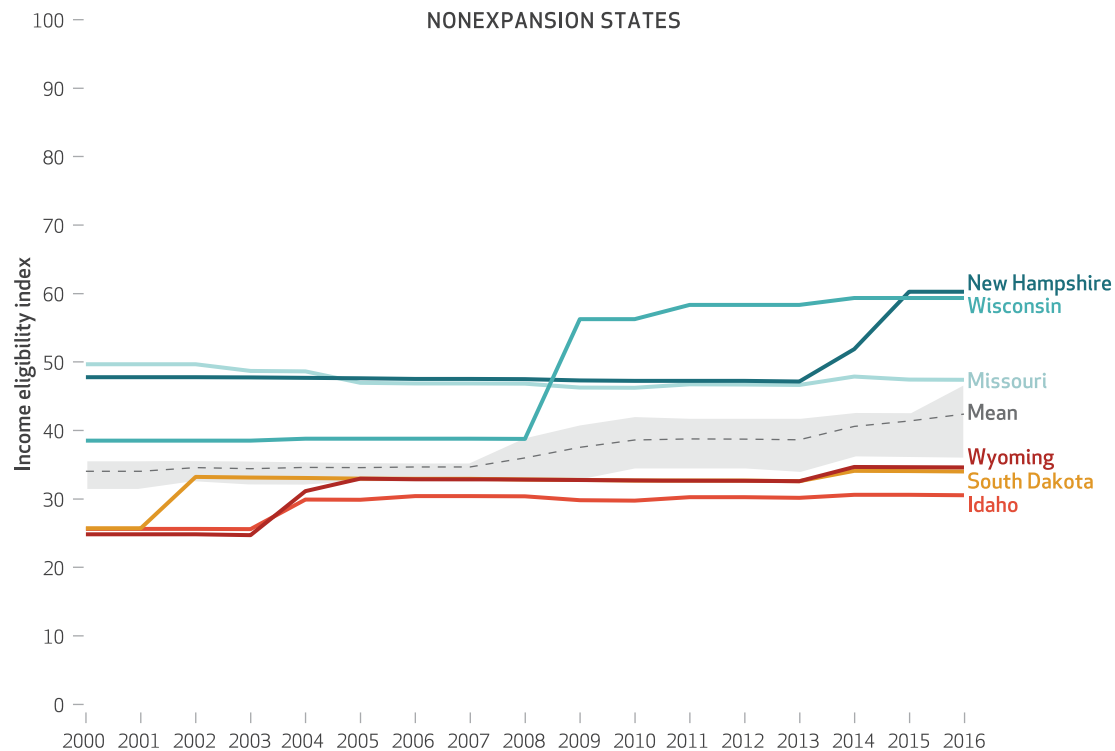
decision was coded such that a higher score represents a more expansive Medicaid policy choice.

We constructed several indices. The eligibility index is based on Medicaid income eligibility limits across different categorical eligibility groups (children ages zero to eleven months, one to five years, and six to eighteen years; pregnant women; and low-income parents) plus the ACA Medicaid expansion for adults without dependents and with income up to 133 percent of the federal poverty level. The administrative burden index captures the variation in reductions in onerous enrollment and renewal rules, such as eliminating asset tests and face-to-face interviews among different categorical eligibility groups. The immigrant eligibility index measures whether lawful permanent residents and unauthorized immigrants are eligible for Medicaid for children, pregnant women, and adults. Benefit comprehensiveness measures whether the state covers optional and mandatory benefits and whether copays are required for each benefit.

A more detailed explanation of how the index

EXHIBIT 3

Trends in the income eligibility index in nonexpansion states, 2000-16



SOURCE Authors’ analysis of data from the Kaiser Family Foundation’s 50-state survey of Medicaid and Children’s Health Insurance Program eligibility, enrollment, and cost-sharing policies. **NOTES** The income eligibility index is defined in the exhibit 2 notes. The three states with the lowest and highest values on average during the period examined are identified. Data are directly observed for all years except 2007 (2006 data were used for 2007) and 2001 (data from 2000 were used for 2001). The twenty-fifth and seventy-fifth percentiles are indicated by the shaded area.

and subindices were constructed is in the online appendix.¹⁰ The index and subindices range from 0 to 100, where 100 is equivalent to states adopting all policies under a given dimension or all income eligibility groups reaching 400 percent of the federal poverty level; 0 means that none of the policies were adopted.

We graphed the panel data for each dimension of the index separately for Medicaid expansion states (states that expanded Medicaid in 2014, as prescribed by the ACA) versus states that did not expand Medicaid in 2014. This allowed us to view both overall trends across each dimension over time and differences between Medicaid expansion and nonexpansion states. We included the index mean and the twenty-fifth and seventy-fifth percentiles to measure differences between expansion and nonexpansion states and overall trends.

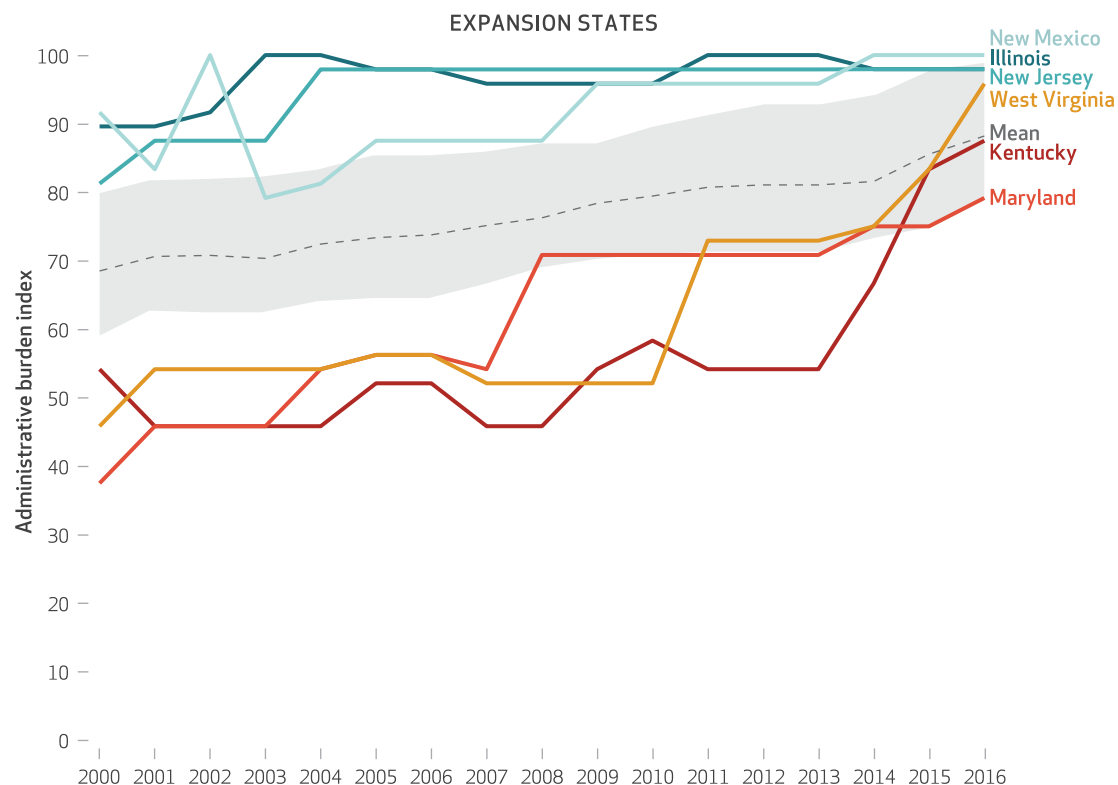
There were some limitations to the data set. First, although we captured multiple dimensions over which state Medicaid programs vary, the rules reported here do not include all the ways

state Medicaid programs differ and are limited to those collected through the Kaiser Family Foundation's survey. For instance, we did not capture states that have undertaken so-called Section 1115 waivers (after Section 1115 of the Social Security Act) and shifted from fee-for-service Medicaid to Medicaid managed care. This is partly because it is not clear what effect these decisions have on coverage and access. A number of states have also recently applied for Section 1115 waivers to expand Medicaid, but with additional restrictions such as work requirements or premium payments. Medicaid reimbursement rates constitute another important dimension that is not captured here.

Finally, we could not be certain of the exact timing of the implementation of any specific rule changes from one year to the next, and we needed to impute some missing years of data, especially for benefits, which may have limited our analyses undertaking causal inference (see the appendix for more detail).¹⁰

EXHIBIT 4

Trends in the administrative burden index in expansion states, 2000-16



SOURCE Authors' analysis of data from the Kaiser Family Foundation's 50-state survey of Medicaid and Children's Health Insurance Program eligibility, enrollment, and cost-sharing policies. **NOTES** The administrative burden index was measured in terms of the number of streamlined enrollment and renewal efforts made by a state out of the total efforts measured across categorical eligibility groups. The three states with the highest and lowest values on average during the period examined are identified. Data are directly observed for all years except 2010 (2009 data were used for 2010) and 2001 (data from 2000 were used for 2001). The twenty-fifth and seventy-fifth percentiles are indicated by the shaded area.

Study Results

Medicaid expansion states have, on average, higher index values than nonexpansion states across all dimensions across the full time frame. For instance, the mean income eligibility index for expansion states was 45 (exhibit 2) versus 37 for nonexpansion states (exhibit 3) over the full period. For administrative burden, the mean index value was 77 over time for expansion states (exhibit 4) and 74 for nonexpansion states (exhibit 5). The mean benefit and copay index value over all years examined was 77 for expansion states (exhibit 6) versus 68 for nonexpansion states (exhibit 7). The largest difference that distinguished the expansion states from nonexpansion states concerned the treatment of immigrants. The mean immigrant eligibility index value over the full period was 44 for expansion states and 21 for nonexpansion states (see figure A6 in the appendix).¹⁰

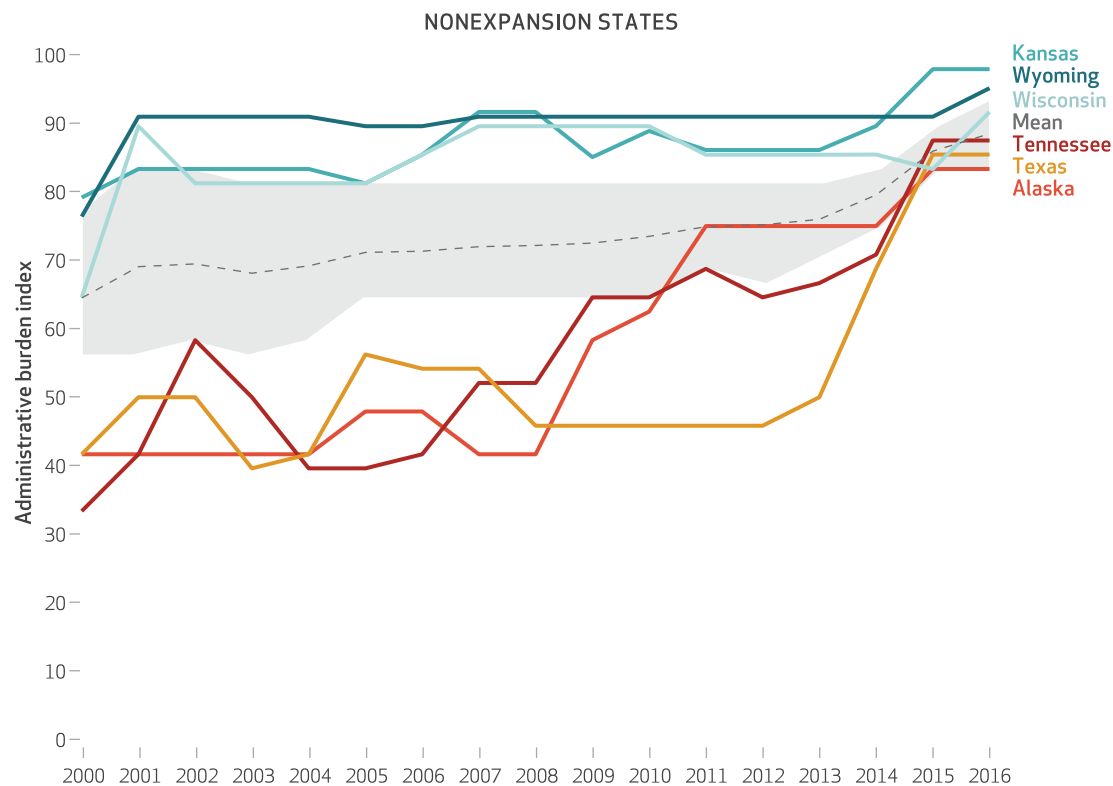
Although expansion states had higher index values than nonexpansion states, both expansion and nonexpansion states have been trend-

ing upward in their eligibility and administrative burden indices, especially after 2014. In contrast, benefit and copay and immigrant eligibility indices have largely been flat across states, regardless of expansion status. Benefit and copay indices decreased across a number of states between 2012 and 2018, particularly in Nevada and New Hampshire, as a number of optional benefits were dropped or copayments added. No state has adopted all of the possible policy reforms that would maximize eligibility levels, minimize administrative barriers to enrollment, and provide all allowable benefits and eliminate copays—meaning that all states do less than the federal government permits.

The states and localities with the highest composite index values between 2000 and 2016 across all categories were Washington, D.C.; New York; and Massachusetts. Those with the lowest were Mississippi, Alabama, and Kentucky. Tables A3 and A4 in the appendix provide detailed state rankings for the composite index and across the four dimensions.¹⁰

EXHIBIT 5

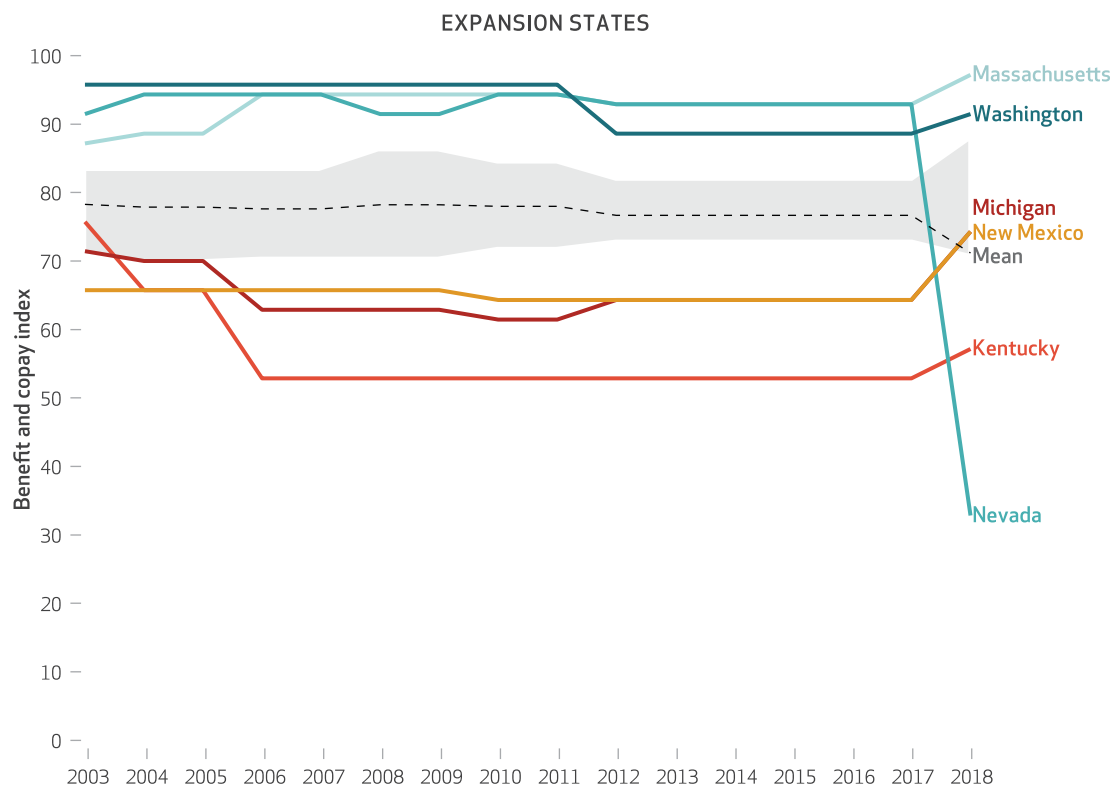
Trends in the administrative burden index in nonexpansion states, 2000-16



SOURCE Authors' analysis of data from the Kaiser Family Foundation's 50-state survey of Medicaid and Children's Health Insurance Program eligibility, enrollment, and cost-sharing policies. **NOTES** The administrative burden index is defined in the exhibit 4 notes. The three states with the highest and lowest values on average during the period examined are identified. Data are directly observed for all years except 2010 (2009 data were used for 2010) and 2001 (data from 2000 were used for 2001). The twenty-fifth and seventy-fifth percentiles are indicated by the shaded area.

EXHIBIT 6

Trends in the benefit and copay index in expansion states, 2003–18



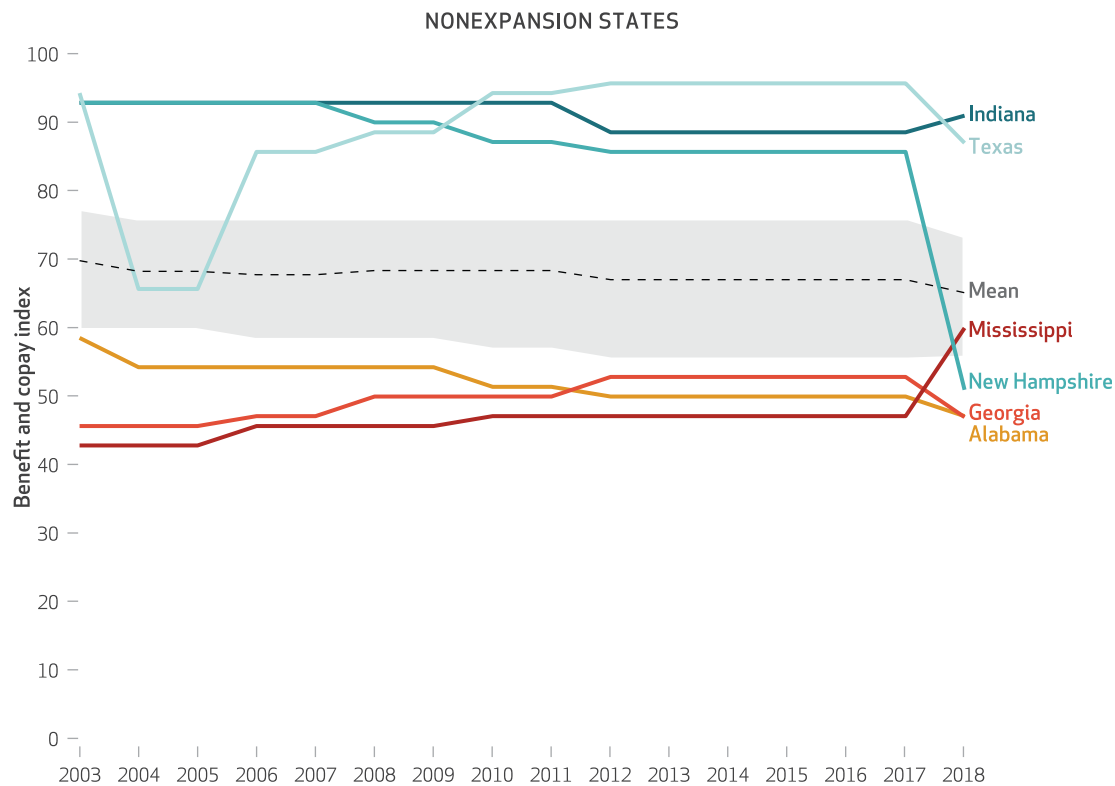
SOURCE Authors' analysis of data from the Kaiser Family Foundation's Medicaid benefits database. **NOTES** The benefit and copay index was measured as the number of optional services covered and not requiring a copay out of the total number possible. Data were available starting in 2003. The three states with the highest and lowest values on average over the time period are identified. Data are directly observed for 2003, 2004, 2006, 2008, 2010, 2012, and 2018. For other years, data from the previous year were used. For 2013 to 2017, directly observed data from 2012 were used. The twenty-fifth and seventy-fifth percentiles are indicated by the shaded area.

Discussion

This analysis illustrates several ways in which states vary in their Medicaid policies apart from whether the state has undertaken the expansion of program eligibility to adults without dependents. States that have not expanded Medicaid, on average, have lower index values than states that chose to expand Medicaid on schedule in 2014. However, this is not solely a result of these states' failure to expand Medicaid to adults without dependents; rather, these states also perform unfavorably, on average, across a range of other measures, including income thresholds for other categorical eligibility groups, reduced administrative burden in enrollment and renewal, expanding benefits with no cost sharing, and eligibility for immigrants. This finding has implications for studies examining the impact of Medicaid expansion on health-related outcomes, as it suggests that these studies might need to account for the broader ways in which Medicaid programs vary across states.

Although there are differences between expan-

sion and nonexpansion states, overall, states have been trending in the direction of higher index values, in terms of both income eligibility thresholds and enrollment or renewal rules aimed at reducing administrative burden, although less so in terms of benefits and easing of immigration restrictions. The reduction in administrative burden may be at least partially a result of inducements from the federal government aimed at reducing administrative burden. For instance, the Children's Health Insurance Program Reauthorization Act of 2009 included a "performance bonus," which provided extra financial support to states that succeeded in enrolling Medicaid-eligible children above target levels.¹¹ To qualify, states need to have implemented at least five of eight policies designed to streamline enrollment and renewal procedures in their Medicaid and CHIP programs. The apparent convergence of states in their streamlining of enrollment and renewal process after 2009 and after the adoption of the ACA suggests that the federal government can effec-

EXHIBIT 7**Trends in the benefit and copay index in nonexpansion states, 2003-18**

SOURCE Authors' analysis of data from the Kaiser Family Foundation's Medicaid benefits database. **NOTES** The benefit and copay index is defined in the exhibit 6 notes. Data were available starting in 2003. The three states with the highest and lowest values on average during the period examined are identified. Data are directly observed for 2003, 2004, 2006, 2008, 2010, 2012, and 2018. For other years, data from the previous year were used. For 2013 to 2017, directly observed data from 2012 were used. The twenty-fifth and seventy-fifth percentiles are indicated by the shaded area.

tively induce policy convergence in states (exhibits 4 and 5). These variations, although seemingly minor, are consequential for whether or not certain groups of people are able to access health coverage and the benefits this yields, and they contribute to cross-state inequality.⁵

The study also suggests that there is more states can do to expand income eligibility to categorical eligibility groups other than adults without dependents. Even before the Medicaid expansion, states diverged greatly in their income eligibility thresholds for different categorical eligibility groups. Eligibility levels for parents warrant particular attention, as they are considerably lower than those for children, pregnant woman, or adults without dependents, especially in nonexpansion states.

Future analyses can investigate differences in the policy environment or incentives that lead

to decisions to provide more expansive Medicaid programs. Additional analyses can investigate the association between specific Medicaid policies and their impact on health, as well as the causes of variation in state Medicaid policy.

Conclusion

States vary widely in their adoption of policies aimed at increasing enrollment and providing more expansive coverage for Medicaid and CHIP. Although eligibility and enrollment rules have become more expansive over time, eligibility for immigrants and benefit coverage have been more static or decreasing across states. Both expansion and nonexpansion states have room to reform their eligibility, enrollment, and benefit levels to improve uptake and expand their Medicaid programs. ■

A previous version of this article was presented at the AcademyHealth Annual Research Meeting in Washington, D.C., June 4, 2019. This research received support from the Robert Wood Johnson Foundation Public Health Law Program, Grant No. 72274.

NOTES

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