Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

June 1, 2017

African American Uninsured Rate Dropped by More Than a Third Under Affordable Care Act

Repealing ACA and Cutting Medicaid Would Undercut Progress

By Peggy Bailey, Matt Broaddus, Shelby Gonzales, and Kyle Hayes

The Affordable Care Act's (ACA) expansion of Medicaid and reforms to the individual insurance market, including subsidized coverage for people with incomes up to four times the poverty line, have helped to lower the uninsured rate for nonelderly African Americans by more than one-third between 2013 and 2016, from 18.9 percent to 11.7 percent. But there is room for improvement. African Americans have higher uninsured rates than whites (7.5 percent) and Asian Americans (6.3 percent).[1,2] The likelihood of having health coverage shouldn't vary by a person's race or ethnicity; building on the success of the ACA could go a long way to eliminating health insurance coverage disparities, while repealing the ACA and cutting Medicaid would reverse recent progress.

Expanding health coverage among African Americans is critical to addressing disparities in health *outcomes* for this population. A greater share of African Americans report fair or poor health status than their white counterparts.[3] Nonelderly African Americans have death rates that are more than 40 percent higher than their white counterparts and are more likely to have diseases like high blood pressure, diabetes, and stroke at younger ages.[4]

While the ACA has produced significant progress in reducing the uninsured rate among African Americans — and among the U.S. population as a whole — some states haven't fully realized their

[1] Robin A. Cohen, Emily P. Zammitti, and Michael E. Martinez., "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2016," National Center for Health Statistics, May 2017, https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf.

[2] The National Health Interview Survey data are the most recent health insurance coverage estimates available and reflect preliminary survey results for 2016. We use this source for national-level estimates in this paper. The Census Bureau's Current Population Survey (CPS) shows a similar reduction in the uninsured rate among non-elderly African Americans, from 17 percent in 2013 to 12 percent in 2015.

[3] Kaiser Family Foundation, "Percent of Adults Reporting Fair or Poor Health Status, by Race/Ethnicity," 2015, http://kff.org/other/state-indicator/percent-of-adults-reporting-fair-or-poor-health-status-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[4] Centers for Disease Control and Prevention, "African American Health: Creating Equal Opportunities for Health," May 2017, https://www.cdc.gov/vitalsigns/pdf/2017-05-vitalsigns.pdf.

opportunity to increase coverage because they haven't yet adopted the ACA's Medicaid expansion for low-income adults. Of the 28 states that adopted expansion by January 1 2015, 25 had uninsured rates for African Americans at or below the national average.[5]

Moreover, insurance coverage gained through the ACA is now under significant threat. The House Republican bill to repeal the ACA — the American Health Care Act (AHCA) — would cause 23 million people to lose health coverage,[6] and recent and anticipated executive actions by the Trump Administration would take away health insurance coverage from millions, large numbers of whom are African Americans. Specific threats include:

- **Repealing the Medicaid expansion and radically changing Medicaid financing.** The AHCA effectively repeals the Medicaid expansion and imposes a per capita cap on Medicaid as a whole.[7] These changes would cut federal Medicaid funding by $834 billion, forcing states to make up the difference or, more likely, cut eligibility, benefits, and provider payment rates.[8]

  Health coverage and access to health care services would be at risk for all Medicaid beneficiaries if funding were capped, but this change would disproportionately harm African Americans, 15 million of whom are enrolled in Medicaid.[9] African Americans make up 13.3 percent of the U.S. population but 19 percent of Medicaid enrollees.[10]

- **Erecting barriers to Medicaid coverage.** Health and Human Services (HHS) Secretary Tom Price and Centers for Medicare & Medicaid Services Administrator Seema Verma have informed governors that HHS is willing to approve Medicaid changes like instituting work requirements, drug testing, and increased cost-sharing.[11] These policies likely would significantly reduce Medicaid enrollment by dropping people from coverage and discouraging people from enrolling in the first place.

---

[5] CBPP analysis of American Community Survey data for 2015, United States Census Bureau.

[6] Congressional Budget Office, "H.R. 1628: American Health Care Act," May 24, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.

[7] For more on per capita caps, see Edwin Park, "Medicaid Per Capita Cap Would Shift Costs and Risks to States and Harm Millions of Beneficiaries," Center on Budget and Policy Priorities, February 27, 2017, http://www.cbpp.org/research/health/medicaid-per-capita-cap-would-shift-costs-and-risks-to-states-and-harm-millions-of.

[8] Congressional Budget Office, "H.R. 1628."

[9] CBPP analysis of Medicaid Budget & Expenditure System administrative data and American Community Survey data. For total number of Medicaid enrollees: Centers for Medicare & Medicaid Services, "Total Medicaid Enrollees – VIII Group Break Out Report," December 2016, https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-jan-mar-2016.pdf. For proportion of enrollees who are non-Hispanic African American (20 percent in 2015), CBPP analysis of 2015 American Community Survey public use file.

[10] Census Bureau, "Quick Facts, United States," https://www.census.gov/quickfacts/table/PST045216/00#headnote-js-a; Kaiser Family Foundation, "Distribution of the Nonelderly with Medicaid by Race/Ethnicity," http://kff.org/medicaid/state-indicator/distribution-by-raceethnicity-4/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D .

[11] HHS Secretary Tom Price and CMS Administrator Seema Verma letter to governors, March 14, 2017, https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf.

- **Undermining enrollment in ACA marketplaces.** Continued efforts to repeal the ACA, along with administrative actions to undermine the stability of the marketplaces, are creating uncertainty among insurers regarding their continued participation in the marketplaces, as well as confusion among potential enrollees.[12] Destabilizing the marketplaces would put the ACA's coverage gains at risk for African Americans and others who've benefited under the ACA. Over 660,000 African Americans were among the 12 million people who signed up for ACA marketplace health plans during the 2017 open enrollment period in the 39 states that use the Healthcare.gov enrollment platform.[13]

Rather than fostering an environment of uncertainty, the Administration should seek to strengthen coverage through the marketplaces, which — along with more states' adoption of the Medicaid expansion — would help close the coverage gap for African Americans. Federal and state officials and other stakeholders could take steps such as identifying areas with high concentrations of eligible but unenrolled African Americans, focusing additional resources there on increasing awareness about the availability of marketplace coverage, and strengthening partnerships with groups that have expertise in conducting outreach to African Americans.

Health Coverage Is Critical to Addressing Health Outcome Disparities for African Americans

Health coverage is not enough on its own to ensure good health outcomes, but it is critical. Without health coverage, people often forgo regular doctor's appointments, don't take necessary prescription medication, and delay care, resulting in emergency room visits and inpatient hospital stays that are expensive and often avoidable.[14]

Health coverage is especially important for African Americans and other racial and ethnic minorities because they often have worse health status than their white counterparts. African Americans live with chronic conditions such as diabetes, heart disease, and HIV/AIDS at far greater rates than other racial groups.[15] The African American diagnosis rate for HIV of 60 per 100,000 is almost triple that of Hispanics (24 per 100,000), the second-highest group, and higher still than whites and Asian Americans, who tie for the lowest diagnosis rate (7 per 100,000).

The ACA has improved access to health care services for those who gained coverage through its coverage expansions. People who were uninsured in 2013 and gained either marketplace or Medicaid coverage in 2014 were likelier than their counterparts who remained uninsured to report having a usual source of care, receiving an annual checkup, and getting a blood pressure screening.[16]

---

[12] Center on Budget and Policy Priorities, "Sabotage Watch: Tracking Efforts to Undermine the ACA," http://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca.

[13] Centers for Medicare & Medicaid Services, "Health Insurance Marketplace 2017 Open Enrollment Period Final Enrollment Report: November 1, 2016 – January 31, 2017," March 31, 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html.

[14] Kaiser Family Foundation, "Key Facts about the Uninsured Population," September 29, 2016, http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

[15] Samantha Artiga *et al.,* "Key Facts on Health and Health Care by Race and Ethnicity," Kaiser Family Foundation, June 2016, http://files.kff.org/attachment/Chartpack-Key-Facts-on-Health-and-Health-Care-by-Race-and-Ethnicity.

Also, research focusing on the first two years of the ACA's Medicaid expansion found improvements in various measures of access to care, including affording needed follow-up care, having a personal doctor, and having access to medications.[17]

Some States' Failure to Expand Medicaid Has Limited Progress in Closing Coverage Gap

Unfortunately, states that haven't expanded Medicaid haven't fully realized their opportunity to increase coverage. Under the ACA, states have the option to cover adults with incomes up to 138 percent of the poverty line ($16,642 for an individual, $28,179 for a family of three in 2017).[18] To date, 31 states and the District of Columbia have adopted the expansion. In the 19 states that haven't, many adults with incomes below the poverty line are caught in a "coverage gap," with incomes too high for Medicaid but too low to qualify for subsidized marketplace coverage. (Subsidies are generally only available to people with incomes between 100 and 400 percent of the poverty line.) If the 19 non-expansion states expanded, about 806,000 African Americans would come out of the coverage gap and become newly eligible for Medicaid.[19]

In 2015, the uninsured rate for African Americans was at or below the national average of 12.1 percent in 25 of the 28 states that had expanded Medicaid at that time. Only 4 of the 23 states that had not expanded Medicaid had an uninsured rate for African Americans that was at or below the national average.[20] (See Appendix Table 1.) One of those four states — Wisconsin — provided Medicaid coverage to nonelderly adults with incomes up to the poverty line through a Medicaid waiver and another state — Maine — provided Medicaid to parents with incomes up to 105 percent of the poverty line.

Among the ten states with the largest African American populations, the non-expansion states all had significantly higher uninsured rates among African Americans than the expansion states. (See Table 1.) For example, 17.3 percent of African Americans are uninsured in Florida, which didn't expand Medicaid, and 7 percent of African Americans are uninsured in California, which did.

TABLE 1

Uninsured Rate in Ten States with Largest Non-Elderly African American Populations

[16] James Kirby and Jessica Vistnes, "Access to Care Improved for People Who Gained Medicaid or Marketplace Coverage in 2014," *Health Affairs*, October 2016, pp. 1830-1834.

[17] Sarah Miller and Laura Wherry, "Health and Access to Care during the First 2 Years of the ACA Medicaid Expansions," *New England Journal of Medicine,* March 2017, pp. 947-956; Kosali Simon, Aparna Soni, and John Cawley, "The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the First Two Years of the ACA Medicaid Expansions," *Journal of Policy Analysis and Management,* 2017, pp. 390-417; Benjamin Sommers *et al.,* "Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act," *Journal of the American Medical Association*, July 2015, pp. 366-374.

[18] Annual Update to the HHS Poverty Guidelines, 82 Fed. Reg. 19 (2017).

[19] Rachel Garfield and Anthony Damico, "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid," Kaiser Family Foundation, October 19, 2016, http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

[20] CBPP analysis of American Community Survey data for 2015, United States Census Bureau.

State	Percent of non-elderly African Americans without health insurance	Total number of non-elderly African Americans
Florida*	17.3%	2,741,661
Louisiana**	16.1%	1,304,363
Texas*	15.9%	2,838,733
Georgia*	15.8%	2,804,597
Virginia*	13.0%	1,341,799
North Carolina*	12.7%	1,854,281
New York	9.1%	2,435,595
Illinois	8.7%	1,555,624
Maryland	7.9%	1,510,023
California	7.0%	1,844,384

* Non-expansion state

** State did not expand Medicaid until 2016

Source: 2015 American Community Survey

Federal and State Medicaid Proposals Would Create Barriers to Coverage

The federal government pays a fixed share of states' Medicaid costs, varying by state but averaging about 64 percent.[21] Federal funding expands automatically when a state's need grows, which ensures that states receive federal support to meet increasing demand, including for public health challenges such as the Zika virus or opioid addiction.

The AHCA would radically restructure Medicaid by converting it to a per capita cap or giving states the option for a block grant for adults and children. Coupled with repeal of the Medicaid expansion, the bill would cut federal Medicaid spending by $834 billion over ten years.[22] Shifting such a large share of costs to states would likely force them to cut services, reduce eligibility, and reduce provider payments. States might also have to stop improvements including new service delivery models (such as in-home prenatal care for pregnant women), expanded mental health services, and new substance use disorder treatment methods (such as medically assisted treatment or residential care).[23]

In addition to the threat posed by the AHCA, some states are seeking federal permission to impose unprecedented conditions on Medicaid coverage, including work requirements, enforceable premiums and copays, and drug testing.[24] By erecting barriers to eligibility and coverage, these

[21] Congressional Budget Office, "Detail of Spending and Enrollment for Medicaid for CBO's January 2017 Baseline," January 2017, https://www.cbo.gov/sites/default/files/recurringdata/51301-2017-01-medicaid.pdf.

[22] Congressional Budget Office, "H.R. 1628."

[23] Edwin Park, Judith Solomon, and Hannah Katch, "Updated House ACA Repeal Bill Deepens Damaging Medicaid Cuts for Low-Income Individuals and Families," Center on Budget and Policy Priorities, March 21, 2017, http://www.cbpp.org/research/health/updated-house-aca-repeal-bill-deepens-damaging-medicaid-cuts-for-low-income.

proposals would result in fewer low-income people having coverage and receiving needed health care:

- **Work requirements.** Work requirements have never been allowed in Medicaid, and evidence from the Temporary Assistance for Needy Families program shows they are ineffective in connecting people to long-term employment and reducing poverty.[25]
- **Enforceable premiums for people with incomes below the poverty line.** A robust body of research shows that premiums reduce eligible beneficiaries' participation in health care programs and that cost-sharing keeps people from obtaining necessary health care services.[26] While a few states, including Arizona, Indiana, and Montana, have imposed premiums and co-pays in Medicaid, they do not take away coverage completely for failure to pay. There are concerns that the Trump Administration will approve new proposals, like those from Wisconsin and Maine, which are harsher and would require extremely low-income adults to pay premiums or lose coverage for three to six months. These proposals would force people to choose between paying for health insurance and other necessities, such as food or housing.
- **Drug screening and testing.** Wisconsin plans to ask federal permission to drug-test Medicaid beneficiaries whom the state suspects of using drugs, with a failed test resulting in mandated treatment.[27] Seven states (Arizona, Kansas, Mississippi, Missouri, Oklahoma, Tennessee, and Utah) have instituted drug testing programs under TANF, and evidence shows they often cost more to administer than any savings from denying TANF benefits to the few who test positive.[28] In addition, the results are often inaccurate due to certain medical conditions (such as kidney disease) or legitimate prescription drug use.[29]

While capping Medicaid funding or creating barriers to eligibility would jeopardize health coverage and health care services for all Medicaid beneficiaries, it would disproportionately affect African Americans. Of the 74 million people enrolled in Medicaid as of March 2016, an estimated 15

---

[24] Associated Press, "Arkansas governor signs new Medicaid plan restrictions," KATV (ABC), May 4, 2017, http://katv.com/news/local/arkansas-governor-signs-new-medicaid-plan-restrictions; Hannah Katch *et al.*, "Are Medicaid Incentives an Effective Way to Improve Health Outcomes?," Center on Budget and Policy Priorities, January 24, 2017, http://www.cbpp.org/research/health/are-medicaid-incentives-an-effective-way-to-improve-health-outcomes.; Judith Solomon, "Wisconsin Medicaid Proposals Don't Merit Federal Approval," Center on Budget and Policy Priorities, April 25, 2017, http://www.cbpp.org/blog/wisconsin-medicaid-proposals-dont-merit-federal-approval

[25] LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows," Center on Budget and Policy Priorities, June 2016, http://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows.

[26] Kaiser Family Foundation, "Premiums and Cost-Sharing in Medicaid: A Review of Research Findings," February 2013, https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417-premiums-and-cost-sharing-in-medicaid.pdf.

[27] Wisconsin Department of Health Services, "Section 1115 Demonstration Waiver-BadgerCare Reform," April 25, 2017, https://www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm

[28] Bryce Covert, "What 7 states discovered after spending more than $1 million drug testing welfare recipients," ThinkProgress, February 26, 2015, https://thinkprogress.org/what-7-states-discovered-after-spending-more-than-1-million-drug-testing-welfare-recipients-c346e0b4305d.

[29] Department of Health & Human Services Office of the Assistant Secretary for Planning and Evaluation, "Drug Testing Welfare Recipients: Recent Proposals and Continuing Controversies," October 2011, https://aspe.hhs.gov/basic-report/drug-testing-welfare-recipients-recent-proposals-and-continuing-controversies#inherent.

million are African American.[30] African Americans make up 13.3 percent of the U.S. population but 19 percent of Medicaid enrollees.[31]

Moreover, evidence from Indiana suggests that premiums and other changes that states are seeking may disproportionately affect African Americans. Indiana expanded Medicaid through a waiver ("Healthy Indiana Plan" or HIP) that allowed the state to split enrollees into two groups: HIP Plus and HIP Basic. HIP Plus beneficiaries pay premiums but no copayments. HIP Basic beneficiaries — people with incomes below the poverty line — don't pay premiums but do pay copayments for most services. An evaluation found that Basic enrollees go the emergency room more than Plus enrollees, are less likely to have a primary care doctor, and are likelier to have difficulty adhering to prescription medication regimens for conditions like diabetes and high blood pressure.[32] These negative outcomes disproportionately affect African Americans, since they are likelier to be Basic enrollees: HIP Basic includes only 35 percent of HIP beneficiaries overall but half of African American HIP beneficiaries.[33]

Strengthening Marketplace Outreach Would Help Close Remaining Coverage Gap

Over 660,000 African Americans were among the 12 million people who signed up for ACA marketplace health plans during the 2017 open enrollment period in the 39 states that use the Healthcare.gov enrollment platform.[34] This number understates the total number of African Americans receiving coverage in these 39 states because only 63 percent of enrollees provided information about their race or ethnicity to the marketplace. Of enrollees who provided their race, 11.8 percent are African American.[35]

Republican efforts to repeal the ACA, coupled with the Trump Administration's negative statements and actions towards the ACA marketplaces, threaten to destabilize the marketplaces and put the ACA's coverage gains at risk for African Americans and others who've benefited under the ACA.

---

[30] CBPP analysis of Medicaid Budget & Expenditure System administrative data and American Community Survey data. For total number of Medicaid enrollees: Centers for Medicare & Medicaid Services, "Total Medicaid Enrollees —VIII Group Break Out Report." For proportion of enrollees who are non-Hispanic African American (20 percent in 2015), CBPP analysis of 2015 American Community Survey public use file.

[31] Census Bureau, "Quick Facts, United States"; Kaiser Family Foundation, "Distribution of the Nonelderly with Medicaid by Race/Ethnicity."

[32] Judith Solomon, "Indiana's Medicaid Waiver Evaluation Shows Why Kentucky's Medicaid Proposal Shouldn't Be Approved," Center on Budget and Policy Priorities, August 1, 2016, http://www.cbpp.org/sites/default/files/atoms/files/8-1-16health.pdf.

[33] State of Indiana, "Healthy Indiana Plan Demonstration Annual Report." April 29, 2016, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-feb-jan-2016-04292016.pdf.

[34] Centers for Medicare & Medicaid Services, "Health Insurance Marketplace 2017 Open Enrollment Period Final Enrollment Report: November 1, 2016 – January 31, 2017." March 31, 2017.

[35] Paul Guerio and Cara James, "Race, Ethnicity, and Language Preference in the Health Insurance Marketplaces 2017 Open Enrollment Period," Center for Medicare & Medicaid Services, April 2017, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Data-Highlight-Race-Ethnicity-and-Language-Preference-Marketplace.pdf.

Millions would face higher premiums and have higher deductibles under the AHCA. Total out-of-pocket costs (which include premiums, deductibles, copays, and coinsurance) would increase by an average of $3,600 in 2020 for people who buy health insurance through the ACA marketplace.[36] The AHCA would also eliminate key consumer protections, leaving states with the option to expose individuals with pre-existing conditions to unaffordable premiums.

Moreover, the ACA marketplace has begun to show signs of vulnerability related to actions of the Trump Administration. The President began sowing uncertainty when he issued an executive order directing federal agencies to begin dismantling the ACA "to the maximum extent permitted by law." The Administration later announced it intended to stop outreach and advertising during the final week of the open enrollment period — a critical time for consumer sign-ups.[37]

Rather than fostering an environment of uncertainty, the Administration should intensify efforts to reach groups that remain disproportionately uninsured, including African Americans. Steps that HHS, states, and other stakeholders could take include:

- Identifying areas with high concentrations of eligible but unenrolled African Americans and focusing additional resources on increasing awareness about the availability of marketplace coverage in those areas.
- Establishing and strengthening partnerships with groups familiar with enrollment barriers that persist for African American and identifying the best venues and communication vehicles to reach African Americans who are eligible but unenrolled.
- Developing messages and outreach materials targeted at African Americans that promote health insurance.
- Ensuring funding for sufficient navigator programs to conduct outreach and provide application and enrollment assistance in communities with high concentrations of African Americans.

[36] Center on Budget and Policy Priorities, "The House-Passed Health Bill Can't Be Fixed," May 10, 2017. http://www.cbpp.org/sites/default/files/atoms/files/5-9-17health.pdf.

[37] Center on Budget and Policy Priorities, "Sabotage Watch."

APPENDIX TABLE 1

Uninsured Rate for Non-Elderly African Americans Lower in Nearly All States that Expanded Medicaid

State	Total non-elderly African Americans	Number uninsured	Percent uninsured
United States	34,384,400	4,157,200	12.1%
Wyoming	4,500	100	1.6%
District of Columbia	264,900	10,900	4.1%
Vermont	8,300	300	4.1%
Hawaii	19,500	900	4.4%
Massachusetts	403,600	22,200	5.5%
Delaware	174,700	10,500	6.0%
Kentucky	303,400	18,600	6.1%
California	1,844,400	129,900	7.0%
Oregon	63,200	4,500	7.2%
Colorado	189,500	13,800	7.3%
Minnesota	294,900	21,400	7.3%
Washington	227,900	17,100	7.5%
Maryland	1,510,000	119,300	7.9%
Connecticut	312,900	25,900	8.3%
Wisconsin	317,700	26,500	8.3%
Arizona	245,200	20,500	8.4%
Rhode Island	49,800	4,200	8.5%
Michigan	1,184,000	102,300	8.6%
Illinois	1,555,600	135,400	8.7%
New York	2,435,600	221,100	9.1%
Ohio	1,213,000	110,800	9.1%
West Virginia	55,400	5,400	9.7%
Maine	14,100	1,500	10.3%
Arkansas	410,200	43,200	10.5%
Pennsylvania	1,146,700	122,500	10.7%
New Jersey	970,700	103,800	10.7%
Utah	31,800	3,500	11.1%
Nevada	205,900	23,600	11.5%
New Mexico	30,300	3,600	11.8%
Montana	4,300	500	12.2%
North Carolina	1,854,300	234,900	12.7%
Virginia	1,341,800	174,200	13.0%
South Carolina	1,140,200	148,500	13.0%
Alabama	1,128,400	149,200	13.2%
Iowa	92,500	12,200	13.2%
Indiana	529,100	70,800	13.4%

Tennessee	978,200	134,100	13.7%
Missouri	607,000	84,600	13.9%
Mississippi	995,600	147,000	14.8%
Alaska	22,300	3,400	15.1%
Nebraska	83,300	12,800	15.4%
Georgia	2,804,600	444,100	15.8%
Texas	2,838,700	450,700	15.9%
Louisiana	1,304,400	210,100	16.1%
Idaho	8,700	1,500	17.1%
Florida	2,741,700	474,400	17.3%
Kansas	146,700	25,800	17.6%
Oklahoma	238,800	46,000	19.3%
New Hampshire	14,200	3,500	24.3%
South Dakota	11,400	2,800	24.6%
North Dakota	10,400	3,200	30.3%

Note. Shaded states are those that expanded Medicaid to low-income adults under the Affordable Care Act option by January 1, 2015. Alaska, Indiana, Louisiana, and Montana expanded after this date.

Source. American Community Survey, 2015. Estimates are rounded to the nearest hundred.