

Medicaid-Eligible Adults Who Are Not Enrolled: Who Are They and Do They Get the Care They Need?

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There is unprecedented interest in extending public insurance eligibility to greater numbers of low-income parents and other adults. This effort follows on the heels of the latest expansions of eligibility for children through the State Children's Health Insurance Program (SCHIP). Supporters note preliminary evidence that extending Medicaid eligibility to adults may increase the likelihood of enrollment among children (Dubay and Kenney forthcoming; Ku and Broaddus 2000) and that covering adults may have a positive effect on access to care for children. Perhaps more important than potential spillover effects is that insurance coverage is likely to have a positive effect on access to health care and on health status for the adults themselves. Relatively little is known about the characteristics of Medicaid-eligible adults and the potential effects of insurance coverage on their access to care.

In a recent brief (Davidoff et al. 2000), we examined the characteristics, health status, and access to care for children who were eligible for Medicaid, comparing those who enrolled with those who were uninsured or privately insured. We found that those who were uninsured were generally healthier than the enrollees but that they faced greater constraints on access to needed health care. In this brief we analyze adults who are eligible for Medicaid, also comparing those who are uninsured or privately insured with those enrolled in Medicaid. We focus on adults eligible for Medicaid prior to the recent round of expansions. This group is likely to be more economically disadvantaged than the

newly eligible, and the uninsured among them are least able to obtain needed health care.

Adults who are eligible for Medicaid but not enrolled encounter greater obstacles to care than their Medicaid-covered counterparts, according to data from the 1997 National Health Interview Survey. The Medicaid-eligible uninsured adults are less likely to have chronic medical conditions and are in better overall health than their enrolled counterparts, but not all are free of health problems. When uninsured Medicaid-eligible adults are compared with Medicaid-covered adults with the same health status, family income, and other characteristics, the uninsured are more likely to report unmet need, to lack a usual source of care, and to make less use of physician services. Families of the uninsured are more likely to be burdened with out-of-pocket health care costs.

Medicaid-eligible adults with private health insurance coverage do not report barriers to access more often than Medicaid-covered adults. In fact, when health status and other characteristics potentially related to health insurance are taken into account, these adults are less likely to report unmet medical needs than their Medicaid-enrolled counterparts. They are more likely, though, to be burdened by substantial out-of-pocket health care costs.

The National Health Interview Survey—Data and Methods

The primary source of data for this report is the 1997 National Health Interview Survey (NHIS), a large, nationally repre-

Uninsured Medicaid-eligible adults are more likely to report unmet need, lack a usual source of care, and make less use of physician services.

sentative sample of the U.S. noninstitutionalized civilian population.¹ The NHIS collects data on individual demographics, selected acute and chronic medical conditions, general health status, income, current insurance coverage, and access to and use of health care services. We identified adults likely to be eligible for Medicaid through Section 1931 family coverage, the medically needy program, and Section 1115 waiver programs by creating an algorithm that mimics the eligibility determination process.² The algorithm was applied to each adult in the NHIS. Eligibility determination was unaffected by reported insurance coverage.³ Enrollment in Medicaid among nonelderly adults eligible for Medicaid was relatively low; only slightly more than half (51.4 percent) of adults eligible for Medicaid through Section 1931 family coverage, the medically needy program, or Section 1115 waivers were enrolled in 1997. Private coverage was held by 21.6 percent, and an additional 27.0 percent were uninsured. For our eligible adult sample, we compared the characteristics, health status, and access to and use of health care services for those enrolled in Medicaid with those uninsured and those privately insured. We report basic (unadjusted) comparisons of access and use across insurance groups, which describes the experience of the populations of interest. We also estimate the effect of insurance coverage adjusted for a variety of demographic and health status characteristics, which indicates what portion of any gap in access and use is related to insurance coverage.

Differences between Eligible Uninsured and Medicaid-Covered Adults

The uninsured and Medicaid-enrolled groups of Medicaid-eligible adults differ demographically, socially, and economically (table 1). Compared with eligible adults with Medicaid, the uninsured are older and are more likely to be non-Hispanic white or Hispanic, immigrants, married, and male. They are less likely to be very poor (below 50 percent of the federal poverty level [FPL]), and they have fewer children. There are no differences in education, but the uninsured are almost twice as

likely to work full-time, though half still remain unemployed or out of the labor force.

When we compare health status for uninsured Medicaid-eligible adults and Medicaid enrollees (table 2), we find that most report no health problems, but the uninsured are less likely to have health problems than those enrolled in Medicaid. Among the uninsured, only 13.0 percent report being in fair or poor health and 11.3 percent report limitations in activity, compared with 21.0 percent and 20.9 percent, respectively, for Medicaid enrollees. There are no significant differences in patterns of work loss days (among those who are employed) or bed disability days between the two groups. Surprisingly, we find no difference in the prevalence of some chronic conditions such as heart disease, cancer, and diabetes, but the uninsured are less likely than the Medicaid-covered to have other conditions such as hypertension, asthma, ulcer, sinusitis, and chronic bronchitis. The differences in health status are to be expected, because eligible adults are more likely to get enrolled if they seek medical care for a health problem. However, it is clear that not all eligible adults who have health needs are enrolled in Medicaid.

Access to care is clearly more of a problem for the population of eligible uninsured than for Medicaid-covered adults, as the unadjusted comparisons in table 3 show. Almost 42 percent of these uninsured adults lack a usual source of care, compared with about 12 percent of Medicaid-enrolled adults. For those who did have a usual source of care, the type of provider identified is similar for both groups, except that the uninsured are more likely to use a hospital emergency department (5.8 percent vs. 1.8 percent for the Medicaid-enrolled; data not shown in table). The eligible uninsured are much more likely to report unmet need for medical care, dental care, and prescription drugs, and 26.3 percent report delaying seeking care because of the cost, compared with 9.8 percent of those enrolled in Medicaid.

Consistent with their better health and more limited access to providers, fewer eligible uninsured adults use health care than

TABLE 1. Characteristics of Medicaid-Eligible Adults: Uninsured vs. Enrolled (percentage distribution)

Characteristic	Uninsured N = 1,731,000	Medicaid-Enrolled N = 3,233,000
Age (%)		
19–24	23.1	25.6
25–30	25.3	26.1
31–40	28.6	31.2
41+	21.4***	14.4
Sex: Female (%)	69.8***	89.6
Race and Ethnicity (%)		
White, non-Hispanic	47.8**	41.7
Black, non-Hispanic	20.6***	33.4
Hispanic	27.2***	20.8
Other	4.3	4.1
Immigrant	25.3***	14.6
Poverty Level (%)		
<50% of FPL	73.8***	86.4
50–100% of FPL	24.2***	12.6
100–150% of FPL	2.0	1.0
Marital Status (%)		
Married	33.5***	13.1
Divorced/sep/widowed	34.2	34.1
Never married	32.3***	52.7
Education (%)		
Less than high school	43.1	43.1
High school graduate	34.9	34.3
Some college	19.5	20.1
College graduate or more	2.5	2.6
Employment Status (%)		
Works full-time	30.4***	15.9
Works part-time	14.5*	11.5
Not employed	55.2***	72.6
Number and Age of Children (%)		
Number of children	1.7***	2.0
0–1 years	23.4***	30.0
2–6 years	43.2***	54.4
7+ years	53.8	56.4

Source: Urban Institute Analysis of the National Health Interview Survey, 1997.

Number (N) of adults is nationally weighted, rounded to the nearest thousand.

T-tests were performed to compare uninsured to Medicaid enrollees:

*** p < 0.01; ** p < 0.05; * p < 0.10.

FPL = Federal poverty level.

do Medicaid-enrolled adults. Uninsured adults are less likely to have any physician visit within a 12-month period (60.9 percent compared with 87.4 percent for Medicaid-enrolled adults), and they have somewhat fewer visits, if they have any. They are less likely to see a medical specialist (32.4 percent vs. 61.5 percent) or a dentist (35.6 percent vs. 51.2 percent), although there are no differences in the likelihood of vision care or mental health visits (data not shown). They are less likely to have surgery or any overnight hospital stay.⁴ Finally, families of eligible but uninsured adults are much more likely to be burdened by out-of-pocket health care costs. More than 21 percent report spending between \$500 and \$2,000,

compared with fewer than 10 percent of families of Medicaid-enrolled adults (data not shown), and more than 11 percent of families of the eligible uninsured report spending more than \$2,000 out-of-pocket.

Effects of Medicaid Coverage on Health Care Access and Use

The differences between eligible uninsured and Medicaid-enrolled adults provide a useful measure of how much greater the unmet need for care is among uninsured Medicaid-eligibles. The groups differ in their characteristics, though, and thus these differences do not reflect how much of that unmet need could be eliminated if all

TABLE 2. Health Status of Medicaid-Eligible Adults: Uninsured vs. Enrolled

Characteristic	Uninsured	Medicaid-Enrolled
Self-Reported Health Status (%)		
Excellent-good	87.0***	79.0
Fair-poor	13.0***	21.0
Activity Limitations (%)		
No limitations	88.7***	79.1
Limited in major and other activity	11.3***	20.9
Work Loss Days (12 months) (%)		
0-9 days	71.9	74.7
10-19 days	11.5	10.0
20+ days	16.7	15.2
Bed Days (12 months) (%)		
0-9 days	71.5	69.1
10-19 days	12.8	11.7
20+ days	15.7	19.2
Chronic Conditions (%)		
Hypertension (on at least 2 visits)	8.1**	13.1
Heart disease (ever)	5.7	7.7
Cancer (ever)	4.8	3.9
Asthma (attack in 12 months)	4.2***	10.4
Ulcer (12 months)	2.9**	6.6
Diabetes (current treatment with medication)	2.2	2.0
Sinusitis (12 months)	11.4**	16.4
Chronic bronchitis (12 months)	6.2*	10.2

Source: Urban Institute Analysis of the National Health Interview Survey, 1997.

T-tests were performed to compare uninsured to Medicaid enrollees:

*** p < 0.01; ** p < 0.05; * p < 0.10.

Medicaid-eligible uninsured adults were enrolled.⁵

Estimating the effect of lack of Medicaid coverage per se requires statistical adjustment for demographic, social, economic, and health differences between the two groups, the results of which are shown in the third results column in table 3. This column shows how much of the difference in access to care or use of services is attributable to lack of Medicaid coverage. For example, Medicaid-eligible uninsured adults are 26.5 percentage points less likely to have a physician visit in 12 months. Yet, when health and other differences are eliminated from the comparison, the uninsured group is just 17.7 percent less likely to have a physician visit. This is the gap that Medicaid coverage could fill.

All the observed differences in health care access and use remain statistically significant when the (adjusted) effect of Medicaid is the focus, with the exception of the proportion with 10 or more physician visits. Many of the adjusted effects of Medicaid coverage are equal to or larger than the unadjusted effects. For example, uninsured adults are 12.8 percentage

points more likely to report unmet dental needs than their Medicaid-enrolled counterparts. When characteristics of the two groups are taken into account, the effect of Medicaid coverage on unmet dental care needs is 15.0 percent. Therefore, increasing Medicaid enrollment among eligible adults would eliminate many gaps in health care access and use for this group.

Medicaid-Eligible Adults with Private Insurance

Medicaid-eligible adults with private insurance are not generally the focus of public policy concerns. However, low-income persons are more likely to be enrolled in less expensive health plans, either health maintenance organizations (HMOs, which have less cost-sharing but tighter restrictions on access to providers) or less comprehensive fee-for-service plans (where the premiums may be lower but out-of-pocket requirements may be greater). The cost-sharing requirements associated with the fee-for-service plans may create financial barriers to access. This may be an issue particularly for preventive or other services that are less likely to be

TABLE 3. Health Care Access and Use by Medicaid-Eligible Adults: Uninsured vs. Enrolled

Characteristic (%)	Unadjusted Mean Value		Adjusted Difference in Mean Value [Medicaid-Enrolled minus Uninsured]
	Medicaid-Enrolled	Uninsured	
No usual source of care	11.6	41.7***	-25.6***
Unmet need (UN) due to cost (12 months)			
Medical	8.9	22.7***	-15.9***
Mental health	5.0	6.3	-1.9
Dental	18.8	31.6***	-15.0***
Prescription	13.7	25.8***	-13.3***
Delayed seeking care due to cost	9.8	26.3***	-18.5***
Any physician/other provider visit	87.4	60.9***	17.7***
10 or more physician visits	26.9	19.4*	4.5
Any surgery	17.7	9.0***	7.0**
Any overnight hospital stay	23.1	13.8***	3.7*
Family spending ≥ \$2,000	4.1	11.1***	-6.0***

Source: Urban Institute Analysis of the National Health Interview Survey, 1997.

T-tests were performed to compare unadjusted means for uninsured and Medicaid enrollees; adjusted differences controlled for age, race, gender, marital status, education, number of children, health status, income, size of metropolitan statistical area, and region of the country.

*** p < 0.01; ** p < 0.05; * p < 0.10.

covered by private insurance plans than by Medicaid. On the other hand, low reimbursement rates under Medicaid and resulting low levels of physician participation may result in constrained access for Medicaid enrollees compared with those who have private coverage.

Privately insured Medicaid-eligible adults resemble their uninsured counterparts in some ways but not others (data not shown). Compared with the Medicaid-enrolled population, they are somewhat older and more likely to be male. They are even more likely than the eligible uninsured to be non-Hispanic whites, but much less likely than either of the other groups to be Hispanic or immigrants. They have higher incomes than the Medicaid enrollees, they are more likely to be married, and, unlike the uninsured adults, they have higher educational attainment than Medicaid enrollees. They are much more likely to work full-time (40.2%) than are the Medicaid-enrolled (15.9%). Privately insured eligible adults are also more likely to report no health problems than Medicaid enrollees, with fewer in fair or poor health (10.6% vs. 21.0% among enrollees), with activity limitations (13.6% vs. 20.9%), and with heart disease, asthma, ulcer, or chronic bronchitis.

When no adjustment is made for different characteristics of the two populations, patterns of health care access and use among privately insured Medicaid-

eligible adults are similar to those of Medicaid-enrolled adults, as shown in table 4. For example, there is no significant difference in the likelihood they will lack a usual source of care; have unmet needs for mental health services, dental care, or prescription drugs; or delay care because of the cost. For those with a usual source of care, the privately insured are more likely to use a doctor's office or HMO (73.5 percent vs. 53.7 percent; data not shown in table), and there is actually less reported unmet medical care need. The privately insured eligible adults are somewhat less likely to have any physician visit. They are less likely to see a medical specialist (43.8 percent vs. 61.5 percent; data not shown). The biggest burden on the privately insured is in out-of-pocket spending. Nearly 15 percent of privately insured families spend at least \$2,000, compared with 4 percent of Medicaid enrollee families.

As indicated by the adjusted differences presented in table 4, the effect of private coverage in reducing unmet medical need and the positive effect on out-of-pocket spending persist after adjusting for demographic and health status characteristics. The differences in the likelihood of a physician visit and an overnight hospital stay are explained by differences in health status and demographic characteristics, and are not associated with differences in insurance.

TABLE 4. Health Care Access and Use by Medicaid-Eligible Adults: Privately Insured vs. Enrolled

Characteristic (%)	Unadjusted Mean Value		Adjusted Difference in Mean Value
	Medicaid-Enrolled	Privately Insured	[Medicaid-Enrolled minus Privately Insured]
No usual source of care	11.6	16.7	-5.5
Unmet need (UN) due to cost (12 months)			
Medical	8.9	5.0***	3.4***
Mental health	5.0	4.4	-0.5
Dental	18.8	17.1	1.0
Prescription	13.7	12.0	2.7
Delayed seeking care due to cost	9.8	11.7	-2.4
Any physician/other provider visit	87.4	80.8*	3.4
10 or more physician visits	26.9	22.8	1.5
Any surgery	17.7	17.0	-2.7
Any overnight hospital stay	23.1	14.7***	0.1
Family spending ≥ \$2,000	4.1	14.9***	-8.0***

Source: Urban Institute Analysis of the National Health Interview Survey, 1997.

T-tests were performed to compare privately insured and Medicaid enrollees; adjusted differences controlled for age, race, gender, marital status, education, number of children, health status, income, size of metropolitan statistical area, and region of the country.

*** p < 0.01; ** p < 0.05; * p < 0.10.

Implications for Policy

Medicaid-eligible adults who do not enroll and are uninsured face substantial barriers to access, and as a result they use fewer health care services than adults with Medicaid coverage. Although our analysis does not address the health effects associated with reduced access, other researchers have shown links between being uninsured and the prevalence of serious but preventable medical conditions and events (e.g., Bindman et al. 1995). Thus, the reduced use of services likely reduces the general health of these low-income adults. Efforts to increase enrollment in Medicaid, when private insurance alternatives are not available, are essential to maintaining and improving the health of these adults. Our results suggest that covering the uninsured eligible adults (on the margin) would be less expensive because they are healthier than those currently enrolled in Medicaid, though they may have pent-up demand for health care that would need to be served in the short term.

Why would eligible adults who face health problems and high expenses and perceive that they have inadequate access to health care fail to enroll in Medicaid? Time, hassle, stigma, or lack of knowledge may present substantial barriers. The fact that a large proportion of Medicaid-eligible adults who are uninsured face unmet need and delay seeking care because of its cost strongly suggests that such barriers exist.

There have always been uninsured Medicaid-eligible adults. However, barriers to Medicaid enrollment were likely exacerbated by implementation of the federal Personal Responsibility and Work Opportunity Reconciliation Act, which began in 1996 (Families USA 1999; Ku and Garrett 2000).

Since 1997, children's eligibility for Medicaid has expanded substantially through the State Children's Health Insurance Program (SCHIP). In addition, states have made efforts to reverse the effects that welfare reform had on administrative practices associated with Medicaid enrollment. Nevertheless, Medicaid enrollment among adults continued to decline through 2000 (U.S. Census Bureau 2001), even as child enrollment increased, suggesting that greater numbers of very low-income adults are faced with barriers to access. More recent efforts have attempted to expand eligibility for Medicaid or SCHIP coverage to higher-income adults. But if barriers to enrollment cannot be reduced for persons with the lowest income, their access to care will not improve.

Our comparison of privately insured and Medicaid-enrolled adults suggests that private insurance coverage is providing access to care that is comparable to access provided by Medicaid. However, the large out-of-pocket spending associated with these policies represents a substantial

The eligible uninsured are much more likely to report unmet need for medical care, dental care, and prescription drugs.

financial burden to these low-income adults. Relieving them of this burden may further enhance their access to care and free up family resources to meet other basic needs.

Endnotes

1. By using data from 1997 we create a snapshot of Medicaid-eligible adults prior to more recent expansions.
2. The algorithm uses information on family structure, employment, income, assets, and out-of-pocket medical spending to compute countable income and assets. These quantities are compared with federal- and state-specific income and asset thresholds to determine eligibility. The algorithm did capture eligibility for medically needy programs through spend-down. However, most of those identified as medically needy eligible met the higher income thresholds without spend-down. Adults with Medicare or Supplemental Security Income (SSI) were excluded because they have substantial health problems that could skew comparisons across groups. Adults reporting that they had "other public" insurance were also excluded from the analysis, because it was not possible to determine whether they had Medicaid or some other program.
3. Approximately half of adults who reported Medicaid coverage were not deemed eligible through our algorithm and were excluded from this analysis. Some of these individuals may have been pregnant women who are eligible through the poverty-related expansions, but we were not able to model their eligibility through our algorithm. Others may have had transitional Medicaid coverage, available for up to 12 months to families leaving welfare. Ineligible reporters were more likely to be male, above 150 percent of the federal poverty level (FPL), married, and working full-time. These characteristics are consistent with transitional eligibility for two-parent families who left welfare.
4. Some of this difference can be explained by the fact that persons who need these services often come in contact with providers who can enroll them in Medicaid. Some of the difference is likely a consequence of differences in access to care.
5. It is possible that current patterns of coverage reflect selection based on unobserved preferences for care. Thus, the estimated effect of Medicaid on use of services may overstate the true response of the currently uninsured to being enrolled in Medicaid. However, the access constraints faced by the uninsured eligible population suggest that the main reason for failure to enroll is perceived or actual barriers to enrollment rather than preferences for medical care.

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