

ACA Implementation – Monitoring and Tracking

A Look at Early ACA Implementation: State and National Medicaid Patterns for Adults in 2014

September 2016

Genevieve M. Kenney, Jennifer Haley, Clare Pan, Victoria Lynch, and Matthew Buettgens


Robert Wood Johnson
Foundation


URBAN
INSTITUTE

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally.

INTRODUCTION

The Affordable Care Act (ACA) included an expansion of Medicaid aimed at reducing uninsurance among poor and near poor adults under age 65. It was anticipated that Medicaid enrollment would increase under the ACA due to both the expansion of eligibility and the greater take-up of Medicaid among already eligible groups because of the ACA's individual mandate and outreach and enrollment efforts (Kenney et al. 2013). However, the Supreme Court decision of 2012 de facto made the Medicaid expansion optional for states (Rosenbaum and Westmoreland 2012). By mid-2014, 26 states (including the District of Columbia, which for ease of discussion is considered a state in this analysis) had extended Medicaid eligibility to adults below 138 percent of the federal poverty level (FPL), many of whom had not previously qualified for Medicaid coverage (Kaiser Family Foundation 2016). In the remaining states, Medicaid eligibility for adults tended to be much more limited, particularly for adults without dependent children, though changes in rules for determining eligibility under the ACA could affect Medicaid eligibility in those states.

Historically, Medicaid eligibility levels for adults have been quite low, and apart from coverage related to disability or pregnancy, Medicaid eligibility has been more expansive for parents living with dependent children than for other adults (Heberlein, Brooks, Alker, et al. 2013; MACPAC 2012).¹ Due in part to federal minimum requirements, at least some low-income parents were eligible in every state, and the median threshold for working parents was 61 percent of FPL in 2013. There was considerable variation across states, with eligibility thresholds ranging from below 25 percent of FPL in three states to 200 percent of FPL or higher in four states as a result of federal options available before the

ACA (Heberlein et al. 2013). In contrast, because few states provided Medicaid to nondisabled, nonpregnant childless adults regardless of income before the ACA, a higher share of parents than childless adults were eligible for Medicaid (Kenney, Lynch, Haley, and Huntress 2012).

Because of state options and waivers, Medicaid eligibility thresholds for parents and childless adults were already higher in the states that expanded in 2014 than in nonexpansion states. For example, for working parents, expansion states had a median eligibility limit of 106 percent of FPL compared with a median of 48 percent of FPL in nonexpansion states. For childless adults, although the median eligibility threshold was zero in both expansion and nonexpansion states, six expansion states had provided comprehensive Medicaid to nonelderly childless adults without disabilities before 2014 (Heberlein, Brooks, Alker, et al. 2013).

States that have taken up the ACA's Medicaid expansion have done so for all nonelderly adults, with the same thresholds and immigration rules for parents and childless adults. The 2014 threshold is at least 138 percent of FPL (133 percent of FPL plus a 5 percent income disregard) in the 26 participating states (because of their pre-ACA levels, thresholds are higher than 138 percent of FPL for parents in Connecticut, the District of Columbia, and Minnesota and for childless adults in the District of Columbia and Minnesota).² Meanwhile, parents' eligibility thresholds were below FPL in almost all of the 25 remaining nonexpansion states in 2014, with a median threshold of 47 percent of FPL. Only one nonexpansion state, Wisconsin, offered Medicaid to nondisabled childless adults. Although adults

in nonexpansion states with incomes between 100 percent and 138 percent of FPL could be eligible for subsidies for marketplace coverage, those with incomes below 100 percent of FPL who are not eligible for Medicaid do not qualify for any public coverage options (Blumberg et al. 2016; Buettgens and Kenney 2016).

Multiple studies have documented increases in insurance coverage rates among nonelderly adults under the ACA, reflecting the combined effects of new Medicaid enrollment, coverage through newly established marketplaces, and the individual mandate (Blumberg, Garrett, and Holahan 2016; Skopec, Holahan, and Solleveld forthcoming; Kaestner et al. 2015; Martinez, Cohen, and Zammiti 2016; Shartz et al. 2015; Wherry and Miller 2016). This brief is the first published assessment of Medicaid eligibility and take-up among parents and childless adults during 2014, the first year of implementation of the ACA's major coverage provisions. In 2015 and 2016, the number of uninsured continued to fall

and the number of Medicaid enrollees continued to rise. However, survey data allowing an analysis of Medicaid eligibility and take-up are not yet available from the American Community Survey (ACS) for those years.

Using the ACS, we examine levels of insurance coverage, Medicaid eligibility, and Medicaid participation in 2014 for both parents and childless adults nationally, by state, and when grouping states according to 2014 Medicaid expansion status. We also analyze estimated changes in coverage, eligibility, and participation between 2013 and 2014 and compare estimates of Medicaid participation for parents whom we classify as already eligible for Medicaid before 2014 and those whom we classify as newly Medicaid eligible under the ACA. We note greater measurement challenges with the analyses comparing 2013 and 2014 and comparing already eligible and newly eligible adults. This brief serves as a companion to one examining changes in uninsurance, eligibility, and participation among children under age 19 (Kenney et al. 2016).

MAIN FINDINGS

Uninsurance Estimates

- Nationally, although adults' uninsurance levels had been relatively stable for the period from 2008 through 2013, both **parents and childless adults experienced a steep decline in uninsurance between 2013 and 2014, the first year of implementation of the ACA's major coverage provisions.** The **number of uninsured adults fell by over 8 million** between 2013 and 2014, translating to **2.1 million fewer uninsured parents and 6.4 million fewer uninsured childless adults.**
- For both parents and childless adults, **declines in uninsurance were greater in states participating in the ACA's Medicaid expansion** in 2014; these states already had lower uninsurance rates before the ACA, so the changes between 2013 and 2014 led to a **larger coverage differential between expansion and nonexpansion states in 2014 than in 2013.**
- **Uninsurance rates for parents declined between 2013 and 2014 in nearly every state.** By 2014, uninsurance rates for parents ranged from under 5 percent in three expansion states (Hawaii, Massachusetts, and Vermont) to over 20 percent in three nonexpansion states (Florida, Georgia, and Texas). **Nine of the 10 states with the lowest uninsurance rates for parents were Medicaid expansion states, and eight of the 10 states with the highest uninsurance rates were nonexpansion states.**

- **Uninsurance rates for childless adults fell in nearly every state between 2013 and 2014.** In 2014, uninsurance rates for childless adults ranged from 5.5 percent in Massachusetts to above 25 percent in Texas and Florida. **The 10 states with the lowest uninsurance rates for childless adults all participated in the ACA's Medicaid expansion, and eight of the 10 states with the highest uninsurance rates did not participate in the Medicaid expansion.**

Medicaid Coverage Estimates

- In 2014, parents' Medicaid coverage rates ranged from 5.7 percent in Wyoming to 34.4 percent in the District of Columbia, with an estimated **1.1 million additional parents covered by Medicaid in 2014 than in 2013, reaching 9.4 million parents with Medicaid coverage in 2014.** Almost all of this growth in Medicaid coverage (964,000) was in expansion states.
- **The number of childless adults covered by Medicaid rose by 4.4 million, from 12.5 million in 2013 to 16.9 million in 2014, with the growth occurring almost exclusively in expansion states.** By 2014, 11.7 million adults in expansion states reported having Medicaid coverage, compared with 5.2 million in nonexpansion states.

Estimates of Medicaid Eligibility and Participation

- An estimated **46.8 million nonelderly adults were eligible for Medicaid in 2014**, the majority in expansion states. Overall, **70.5 percent of eligible adults without other coverage participated³ in Medicaid**.
- The **2014 participation rate for parents was 73.8 percent**, with wide variation across states, **ranging from 48.4 percent in Texas to 95.9 percent in the District of Columbia and averaging 79.7 percent in expansion states and 63.3 percent in nonexpansion states**, a 16.4 percentage point difference.
- **Four states (District of Columbia, Massachusetts, Rhode Island, and Vermont) had participation rates for Medicaid-eligible parents above 90 percent, and another nine (Connecticut, Delaware, Hawaii, Maine, Maryland, Minnesota, New York, Ohio, and**

Wisconsin) had participation rates between 80 and 90 percent. Of the 13 states with rates of 80 percent or higher, 11 were expansion states, and all had relatively high eligibility levels for parents before 2014.

- The estimated **participation rate among childless adults in 2014 was 68.8 percent**, with childless adults in nonexpansion states (75.7 percent) participating at a higher rate than in expansion states (67.0 percent).

Estimates of Medicaid Eligible but Unenrolled Adults

- In 2014, **28.7 percent of uninsured parents and 25.4 percent of uninsured childless adults were found to be eligible for Medicaid but were not enrolled**, totaling **8.3 million eligible but uninsured adults**, indicating that increased take-up among already eligible adults could further reduce uninsurance among adults.

DATA AND METHODS

Data Source. In this brief, we examine coverage status, eligibility for Medicaid, and participation in Medicaid among adults ages 19 to 64 by using the 2013 and 2014 ACS. (We also examined levels of uninsurance before 2013 by using ACS data from 2008 through 2012.) Each year of the ACS includes a public use sample of over 1.8 million nonelderly adults ages 19 to 64. Separate analyses are conducted for parents and childless adults. A parent is defined as an adult living in a household with a biological child, adoptive child, or stepchild under age 19, and a childless adult is defined as an adult not living with dependent children under age 19.⁴ The ACS is fielded continuously over the course of the year, so the estimates reported here reflect averages for 2013 and 2014, respectively. Estimates for 2014 reflect a very early look at changes following the expansion of Medicaid under the ACA. Some states' expansions did not begin until after January (e.g., Michigan's expansion was not implemented until April 1, 2014, and New Hampshire's until August 15, 2014), and even for states with expansions in place as of January 1, 2014, the full effects of expansion will not be felt for several years (Buettgens et al. 2013). In addition, enrollment has increased since 2014 (Centers for Medicare and Medicaid Services [CMS] 2016), and the ACA's impact on Medicaid coverage, eligibility, and participation is likely to change as the program matures.

Medicaid Eligibility. To assess Medicaid eligibility, we use information about the person and family provided by survey respondents in combination with the Medicaid eligibility rules in place in each person's state of residence in the year in which respondents were surveyed. For 2013, we use the Urban Institute Health Policy Center's Medicaid Eligibility

Simulation Model, which applies the pre-ACA Medicaid eligibility rules for 2013 by using available information on eligibility guidelines, including the amount and extent of income disregards⁵ and asset tests, which varied widely across states (Lynch, Haley, and Kenney 2014). Our model identifies eligibility for comprehensive Medicaid or Medicaid-equivalent benefits by using state rules for major pathways for adults, such as Section 1931 coverage, 1115 waivers in states with such waivers, and other less-common pathways as described below. We also include as eligible in 2013 those who qualify for early ACA expansions in Connecticut, the District of Columbia, and Minnesota (although additional states such as California implemented early ACA expansions, we only include states with statewide, comprehensive early ACA expansions) (Heberlein, Brooks, Alker, et al. 2013).⁶

For 2014, we use the Health Insurance Policy Simulation Model–ACS version (HIPSM-ACS) (Buettgens 2011; Buettgens et al. 2013), which builds on the Medicaid Eligibility Simulation Model and applies rules as defined in the ACA that took effect in 2014. HIPSM-ACS reflects both the increase in eligibility to 138 percent of FPL in participating states and the shift to modified adjusted gross income (MAGI)–based eligibility determination procedures. Eligibility was defined for both MAGI-exempt adults (such as those with disabilities) and MAGI-based adults using MAGI-converted thresholds from CMS. The conversion to MAGI-based eligibility determination involved changes in what income components were counted and which family members' income was included when comparing the family unit's income level to eligibility

thresholds, as well as the conversion of pre-ACA Medicaid eligibility thresholds to MAGI-equivalent thresholds and the elimination of asset tests (CMS 2014a). As detailed in the Methodological Appendix, the MAGI conversion process and new 5 percent disregard effectively increased Medicaid eligibility levels for some individuals even in states not participating in the ACA's Medicaid expansion, particularly for parents. Among the 25 nonexpansion states, the median pre-ACA upper threshold for parents was 31 percent of FPL (before applying any disregards) or 48 percent of FPL (after applying work disregards) in 2013, meaning thresholds effectively varied according to work status and other characteristics. In 2014, these eligibility levels were converted to MAGI-based thresholds that took into account pre-ACA rules and thresholds as well as the average effects of any state-specific pre-ACA income disregards and incorporated a flat 5 percent disregard (Heberlein, Brooks, Artiga, and Stephens 2013). The median threshold among these states was 47 percent of FPL in 2014, with variation across states. Under the ACA, each state has only one parent threshold and, when applicable, only one childless adult threshold for MAGI-based eligibility, eliminating differences in eligibility caused by characteristics such as work status and differences in the eligibility rules for pre-ACA Medicaid eligibility pathways that were not MAGI exempt. Thus, MAGI conversion could affect eligibility for individual adults, with some gaining and others losing eligibility. Eligibility for parents was generally affected more than eligibility for childless adults for two main reasons. First, most states not expanding Medicaid did not offer any income-based public coverage to nondisabled adults without children (unless they qualified as relative caretakers for children in the household or through other less common pathways) in either 2013 or 2014, so there was little or no eligibility to be affected. Second, MAGI conversion often had a larger effect on parents because 2013 parent eligibility criteria were more likely to vary by individual characteristics and to have income disregards or asset tests, distinctions eliminated by the ACA.

We model Medicaid mandatory disability-related eligibility the same way in both 2013 and 2014, by identifying adults with functional limitations and comparing their income to thresholds for aged, blind, and disabled coverage. (Although functional limitation is not directly comparable to disability status as used in program eligibility determination, it is the best approximation of this concept available in this data source.) Some adults with functional limitations will gain income-based coverage under the ACA's higher income thresholds, but income thresholds and eligibility determination procedures for disability-related coverage or for individuals receiving Supplemental Security Income (SSI) benefits were not affected by ACA implementation (Musumeci 2014).

We categorize eligible adults in 2014 as either “pre-ACA” or “newly” eligible. As states can no longer test for eligibility among non-MAGI-exempt groups by using the pre-ACA rules, this distinction does not refer to 2013 eligibility status but rather to reimbursement status under the ACA, for which “new” eligibility refers to adults whose income qualifies them as eligible for the new ACA match rate during the reimbursement process by the U.S. Department of Health and Human Services.⁷ Thus, our newly eligible category corresponds to the new mandatory Medicaid eligibility category established by the ACA. However, it is not a definitive measure of “woodwork effects,” or the extent to which previously eligible individuals enroll during eligibility expansion. Those whom we identify as pre-ACA eligible adults are largely those who would have qualified before 2014 or in the absence of the ACA, and newly eligible adults are largely those who qualify only because of changes in eligibility under the ACA. However, this distinction does not always coincide with the result of applying pre-ACA eligibility rules. In addition to the differences inherent in MAGI conversion discussed above, the 5 percent income disregard does not apply to the new eligible threshold, so conversion may have a larger impact on “new” versus “pre-ACA” eligibility than on thresholds to which the 5 percent disregard applied.

For noncitizens, both the 2013 model and the 2014 model take into account length of U.S. residency in states where this is a factor in eligibility determination, and documentation status is imputed.⁸ To address potential misclassification of coverage on the ACS, we applied a set of coverage edits.⁹

Because of the changes in Medicaid eligibility determination under the ACA, we expect substantial increases in eligibility in expansion states as well as smaller changes in eligibility in nonexpansion states caused by MAGI conversion. We may also find some shifts in eligibility resulting from any changes in the population distribution over this period, such as shifts in income levels. Given the more expansive eligibility for parents than for childless adults in 2013, we expect larger increases in eligibility for childless adults than for parents in expansion states.

Participation. Medicaid participation rates are calculated as the ratio of Medicaid-eligible enrolled adults to the sum of Medicaid-eligible enrolled adults plus Medicaid-eligible uninsured adults, excluding those with both Medicaid and private coverage (including military coverage) and those with Medicaid coverage who do not have a known eligibility pathway. Participation rates that exclude people with private coverage are often used to indicate how successfully Medicaid programs are reaching their primary target populations.

Other things being equal, we would expect that participation among a given group of eligibles would increase over this period given the outreach and enrollment investments that were made. In addition, the ACA's individual mandate could serve to increase coverage for people in expansion states above the tax filing limit who could be subject to the mandate and even for those not directly subject to the mandate (Buettgens et al. 2013). Because research suggests that enrollment of newly eligible groups builds over time following expansions in eligibility (Kenney et al. 2015; Sommers et al. 2013), we expect participation rates among newly eligible parents and childless adults to be lower in 2014 than among the groups who were already eligible for Medicaid under pre-ACA eligibility pathways. Research also suggests that, aside from those with disability-related eligibility, parents tend to participate at higher rates than childless adults (Kenney, Lynch, Haley, et al. 2012), so we anticipate parents' participation would be higher than childless adults' participation in 2014.

Analysis. We examine levels of insurance coverage, Medicaid eligibility, and Medicaid participation nationally, by state, and when grouping states according to Medicaid expansion status as of June 2014 (the middle of the 2014 data collection period, at which point Medicaid programs in 26 states covered adults under the ACA), and we also include analysis of estimated changes in coverage, eligibility, and participation between 2013 and 2014. For parents, we examine changes in participation across states because all states had available coverage for parents in both 2013 and 2014.

Health insurance coverage is measured as status at the time of the survey. This report provides estimates of uninsurance and Medicaid coverage that include those respondents reporting only Medicaid and those reporting Medicaid along with another type of coverage such as a private plan or

Medicare. Medicaid coverage is defined as comprehensive Medicaid, excluding single-service plans such as family-planning services only.

Limitations. As with our prior estimates of health insurance coverage and Medicaid eligibility and participation, and all estimates that rely on survey data and simulated program eligibility, we note that both coverage and eligibility status are likely measured with error. In particular, modeling eligibility for adults in 2013 and 2014 requires different approaches that could over- or understate differences between the two years. The pre-ACA adult eligibility rules for adults are complex and the ACS, like other surveys, does not contain the detail needed to correctly capture important elements of all the major pre-ACA eligibility pathways for adults (e.g., asset tests, pregnancy status, legal disability status, income disregards related to child support, medical spending used to calculate spend-down for medically needy eligibility, duration of enrollment or income history to determine eligibility for Transitional Medical Assistance, or relative caretaker status), which likely leads to understating eligibility under pre-ACA rules. In contrast, MAGI-based eligibility under the ACA relies on a different set of information as measured in survey data, requiring a different set of assumptions and potential sources of bias. As a consequence, we acknowledge the uncertainty around our estimates of eligibility and participation, changes over time, and our attempts to compare participation rates among newly eligible and already eligible parents. Beyond these issues, it is possible that the misclassification of Medicaid and other types of coverage in national surveys has risen since the ACA introduced a new mechanism for obtaining nongroup coverage, which may be of particular concern on the ACS given that it does not include ACA marketplace coverage as a separate category or state specific names for Medicaid. Further detail on the data and methodology is included in the Methodological Appendix (below).

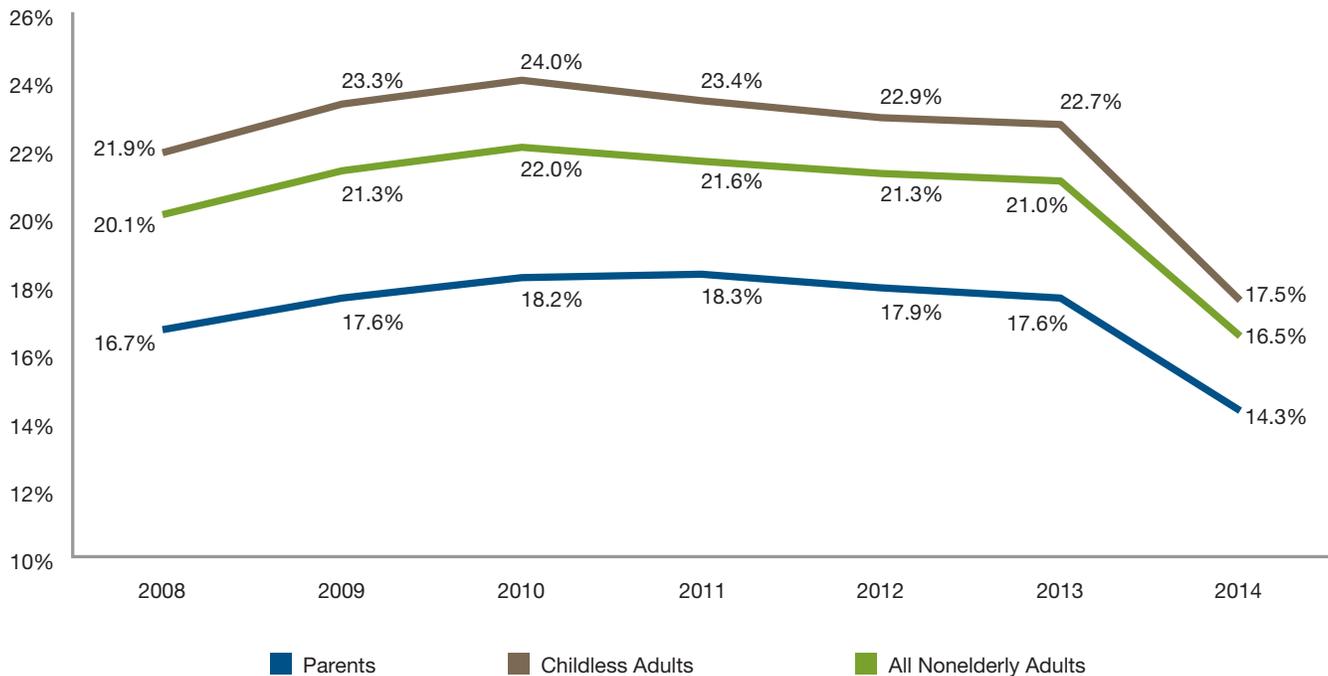
RESULTS

Health Insurance Coverage among Parents and Childless Adults, 2008 to 2014. According to the ACS, national levels of uninsurance for both parents and childless adults were relatively stable from 2008 to 2013, with an estimated 16.7 percent to 18.3 percent of parents and 21.9 percent to 24.0 percent of childless adults lacking coverage each year (Figure 1). In 2013, the uninsurance rate for all nonelderly adults was 21.0 percent, with rates of 17.6 percent for parents and 22.7 percent for childless adults. In contrast, between 2013 and 2014, the uninsurance rate for all nonelderly adults fell from 21.0 percent to 16.5

percent, reflecting a combination of enrollment in the new health insurance marketplaces, changes in private health insurance, and new Medicaid enrollment. This decline was the largest single-year decline observed in uninsurance among nonelderly adults during this period.

Both parents and childless adults experienced steep declines in uninsurance in 2014. For parents, the estimated uninsurance rate fell from 17.6 percent in 2013 to 14.3 percent in 2014, a 3.3 percentage point decline. Among childless adults, who had higher uninsurance rates than

Figure 1. Uninsurance Rates Among Nonelderly Adults, by Parental Status, 2008–2014



Source: Urban Institute tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS)

Notes: Estimates reflect microdata edits for probable misclassified coverage on the ACS. Nonelderly adults are defined as ages 19 to 64. See text for how uninsurance is defined.

parents before 2014, the change was more substantial, with uninsurance falling by 5.2 percentage points between 2013 and 2014, from 22.7 percent to 17.5 percent.

As shown in Table 1, the decline in uninsurance between 2013 and 2014 translated to over 8 million fewer uninsured adults. The number of uninsured parents fell from 10.9 million to 8.8 million, a decline of 2.1 million. Among parents below 138 percent of FPL, the income group targeted by the ACA’s Medicaid expansion, the decline was more pronounced, with the uninsurance rate falling 6.6 percentage points, from 37.0 percent to 30.4 percent (data not shown).

The drop in uninsurance among parents was greater in states participating in the ACA’s Medicaid expansion than in nonexpansion states. As a result, although expansion states had lower uninsurance rates on average than nonexpansion states before the ACA’s implementation (14.9 percent compared with 20.6 percent, a differential of 5.7 percentage points), in 2014 the differential increased to 6.7 percentage points (11.1 percent compared with 17.9 percent). Overall, parents experienced a 3.8 percentage point decline in uninsurance in expansion states and a 2.8 percentage point decline in nonexpansion states. These declines

were concentrated among parents below 138 percent of FPL; their uninsurance rate declined by 8.1 percentage points in expansion states and 5.2 percentage points in nonexpansion states (data not shown).¹⁰

There was also a narrowing in the differential in uninsurance rates for parents and childless adults. The number of uninsured childless adults fell by 6.4 million between 2013 and 2014, from 29.0 million to 22.7 million. As was the case for parents, childless adults’ uninsurance rates fell more in expansion states (6.1 percentage points) than in nonexpansion states (4.1 percentage points), increasing the coverage differential between expansion and nonexpansion states. Among childless adults nationwide below 138 percent of FPL, uninsurance fell from 41.2 percent in 2013 to 30.4 percent in 2014, a decline of over 10 percentage points, representing 3.4 million fewer uninsured childless adults in this income group in 2014 (data not shown). Although childless adults with incomes below 138 percent of FPL were more likely to be uninsured than parents in this income group in 2013 (41.2 percent compared with 37.0 percent), by 2014, their estimated uninsurance rates were the same, at 30.4 percent (data not shown).

Table 1. Rate and Number of Uninsured Nonelderly Adults, by Parental Status and State Expansion Status, 2013 and 2014

	Parents of Dependent Children								
	Total			Expanded Medicaid in 2014			Did Not Expand Medicaid in 2014		
	2013	2014	Change	2013	2014	Change	2013	2014	Change
Uninsurance Rate	17.6%	14.3%	-3.3% **	14.9%	11.1%	-3.9% **	20.6%	17.9%	-2.8% **
Number of Uninsured (thousands)	10,918	8,842	-2,076	4,938	3,663	-1,275	5,980	5,179	-801
	Childless Adults								
	Total			Expanded Medicaid in 2014			Did Not Expand Medicaid in 2014		
	2013	2014	Change	2013	2014	Change	2013	2014	Change
Uninsurance Rate	22.7%	17.5%	-5.2% **	21.1%	15.0%	-6.1% **	24.6%	20.5%	-4.1% **
Number of Uninsured (thousands)	29,037	22,665	-6,372	14,544	10,456	-4,088	14,493	12,209	-2,284
	All Nonelderly Adults								
	Total			Expanded Medicaid in 2014			Did Not Expand Medicaid in 2014		
	2013	2014	Change	2013	2014	Change	2013	2014	Change
Uninsurance Rate	21.0%	16.5%	-4.6% **	19.1%	13.7%	-5.3% **	23.3%	19.7%	-3.7% **
Number of Uninsured (thousands)	39,955	31,507	-8,448	19,481	14,119	-5,363	20,473	17,388	-3,085

Source: Urban Institute tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS)

Notes: See text for how uninsurance is defined.

Estimates reflect microdata edits for probable misclassified coverage on the ACS.

Nonelderly adults are defined as ages 19 to 64.

Numbers are presented in thousands.

**/* indicates estimate is statistically different from 2013 estimate at the .05/.1 levels.

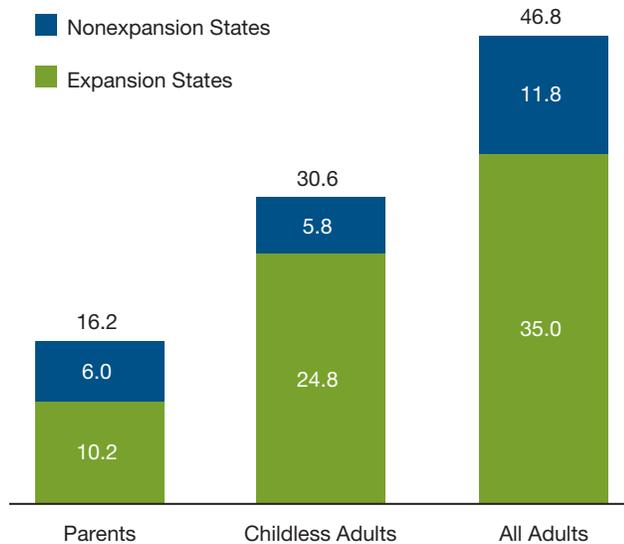
Medicaid Eligibility among Parents and Childless Adults, 2014. Nationwide, an estimated 46.8 million nonelderly adults were eligible for Medicaid in 2014 (Figure 2). Of these, 16.2 million were parents and 30.6 million were childless adults. As would be expected given the much higher average eligibility thresholds in states participating in the ACA's Medicaid expansion than in nonexpansion states, most of these adults live in expansion states: nearly three-quarters of all eligible adults, or 35.0 million, live in expansion states, and 11.8 million live in nonexpansion states. Although every state offers coverage to some low-income parents, the number of eligible parents in expansion states (10.2 million) outnumbers the number of eligible parents in nonexpansion states (6.0 million) because of the higher eligibility thresholds in states participating in the expansion. However, the differential between these groups of states is even greater for childless adults; 24.8 million childless adults in expansion states qualified for Medicaid in 2014, much higher than the 5.8 million in nonexpansion states, most of whom qualified through disability-based pathways.

The number of adults estimated to be eligible for Medicaid in 2014 (46.8 million) is nearly twice as high as in 2013 (24.6 million), with an estimated 4.4 million additional parents

and 17.7 million additional childless adults qualifying for Medicaid in 2014 than in 2013 (Table 2). The estimated number of eligible parents rose from 11.8 million in 2013 to 16.2 million in 2014. Although most of the eligibility increases (2.9 million) were in expansion states, an additional 1.5 million were estimated to qualify for Medicaid in nonexpansion states in 2014, suggesting that the shift in eligibility determination rules under the ACA (as defined by CMS using MAGI-based eligibility with a 5 percent disregard) effectively increased Medicaid eligibility even in states not participating in the ACA's Medicaid expansion. However, as detailed above, part of the increase we observe could reflect differences in measurement of eligibility in the two years caused by data limitations or changes in the population distribution between those two years.

Among childless adults, who had fewer pathways to eligibility before Medicaid expansion under the ACA, the number eligible for Medicaid grew dramatically between 2013 and 2014, more than doubling from 12.9 million to 30.6 million. Almost all of this growth occurred in expansion states, where the number of eligible adults tripled, reaching 24.8 million in 2014. In contrast, eligibility among childless adults was more stable in nonexpansion states because

Figure 2. Number (in millions) of Nonelderly Medicaid-Eligible Adults, by Parental Status and State Expansion Status, 2014



Source: Urban Institute tabulations of 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS)

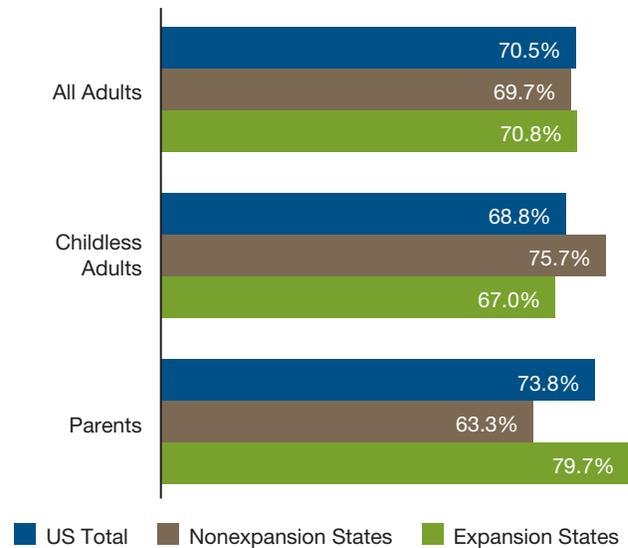
Notes: See text for how eligibility is defined. Estimates reflect microdata edits for probable misclassified coverage on the ACS. Nonelderly adults are defined as ages 19 to 64.

most of these states did not offer public coverage options to nondisabled childless adults in either 2013 or 2014, and disability-based eligibility rules did not change under the ACA. The number of eligible childless adults rose only slightly in nonexpansion states. Wisconsin, which expanded eligibility for childless adults to 100 percent of FPL but did not participate in the ACA's Medicaid expansion, had the majority of eligible childless adults.

Medicaid Participation among Parents and Childless Adults, 2014. The Medicaid participation rate among eligible adults was estimated to be 70.5 percent in 2014 (Figure 3). Nationwide, we find estimated participation for eligible parents and childless adults to be 73.8 percent and 68.8 percent, respectively, in 2014.

Among parents, participation in expansion states (79.7 percent) was higher than in nonexpansion states (63.3 percent) in 2014. In contrast, among childless adults, participation was higher in nonexpansion states (75.7 percent) than in expansion states (67.0 percent). Because most eligible adults in nonexpansion states qualified through disability-related pathways (data not shown), this pattern could reflect the historically higher participation for disability-related eligibility than for income-based eligibility

Figure 3. Medicaid Participation Rates Among Nonelderly Medicaid-Eligible Adults, by Parental Status and State Expansion Status, 2014



Source: Urban Institute tabulations of 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS)

Notes: See text for how eligibility and participation are defined. Estimates reflect microdata edits for probable misclassified coverage on the ACS. Nonelderly adults are defined as ages 19 to 64.

(Kenney et al. 2012). Moreover, as 2014 was the first year for childless adult Medicaid eligibility in most expansion states, this lower participation may reflect low levels of awareness of this new coverage option during its first year. Administrative data indicate that Medicaid enrollment continued to increase in 2015 and 2016, so participation rates among this group are likely to have increased since 2014 (CMS 2016).

Participation among eligible parents appeared to be slightly higher in 2014 than in 2013, rising from 71.7 percent to 73.8 percent nationwide, with the increases occurring almost exclusively among expansion states (Table 2). Parents' Medicaid participation rates fell slightly in nonexpansion states, from 65.1 percent in 2013 to 63.3 percent in 2014, increasing the already substantial participation gap between expansion and nonexpansion states that existed for parents before the ACA. Coinciding with rising Medicaid participation and the ACA-related policy changes introduced between 2013 and 2014, uninsurance among all eligible parents also fell, from 17.9 percent to 15.7 percent. There was a notable decline in uninsurance among eligible parents in expansion states, from 16.1 percent to 12.4 percent.

For childless adults, the estimated Medicaid participation rate was relatively stable in nonexpansion states (at 76.4

Table 2. Medicaid Eligibility, Uninsurance Among Eligibles, and Medicaid Participation Among Nonelderly Adults, by Parental Status and State Expansion Status, 2013 and 2014

	Parents of Dependent Children								
	Total			Expanded Medicaid in 2014			Did Not Expand Medicaid in 2014		
	2013	2014	Change	2013	2014	Change	2013	2014	Change
Number of Medicaid Eligible (thousands)	11,756	16,175	4,418	7,285	10,180	2,895	4,471	5,994	1,523
Uninsurance Rate Among Eligible	17.9%	15.7%	-2.2% **	16.1%	12.4%	-3.7% **	20.8%	21.3%	0.6% **
Number of Eligible Uninsured (thousands)	2,100	2,536	436	1,171	1,257	86	929	1,279	350
Medicaid Participation Rate	71.7%	73.8%	2.0% **	75.5%	79.7%	4.2% **	65.1%	63.3%	-1.8% **
	Childless Adults								
	Total			Expanded Medicaid in 2014			Did Not Expand Medicaid in 2014		
	2013	2014	Change	2013	2014	Change	2013	2014	Change
Number of Medicaid Eligible (thousands)	12,882	30,594	17,712	7,920	24,774	16,854	4,962	5,820	857
Uninsurance Rate Among Eligible	16.6%	18.8%	2.3% **	16.2%	19.5%	3.3% **	17.2%	15.8%	-1.4% **
Number of Eligible Uninsured (thousands)	2,136	5,760	3,624	1,283	4,840	3,557	853	920	67
Medicaid Participation Rate	76.5%	68.8%	-7.7% **	76.5%	67.0%	-9.5% **	76.4%	75.7%	-0.7% **
	All Nonelderly Adults								
	Total			Expanded Medicaid in 2014			Did Not Expand Medicaid in 2014		
	2013	2014	Change	2013	2014	Change	2013	2014	Change
Number of Medicaid Eligible (thousands)	24,639	46,769	22,130	15,205	34,955	19,750	9,434	11,814	2,380
Uninsurance Rate Among Eligible	17.2%	17.7%	0.6% **	16.1%	17.4%	1.3% **	18.9%	18.6%	-0.3% **
Number of Eligible Uninsured (thousands)	4,236	8,296	4,060	2,454	6,097	3,644	1,782	2,198	416
Medicaid Participation Rate	74.4%	70.5%	-3.8% **	76.0%	70.8%	-5.2% **	71.6%	69.7%	-1.9% **

Source: Urban Institute tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS)

Notes: See text for how eligibility, participation, and uninsurance are defined.

Estimates reflect microdata edits for probable misclassified coverage on the ACS.

Nonelderly adults are defined as ages 19 to 64.

Numbers are presented in thousands.

**/* indicates estimate is statistically different from 2013 estimate at the .05/.1 levels.

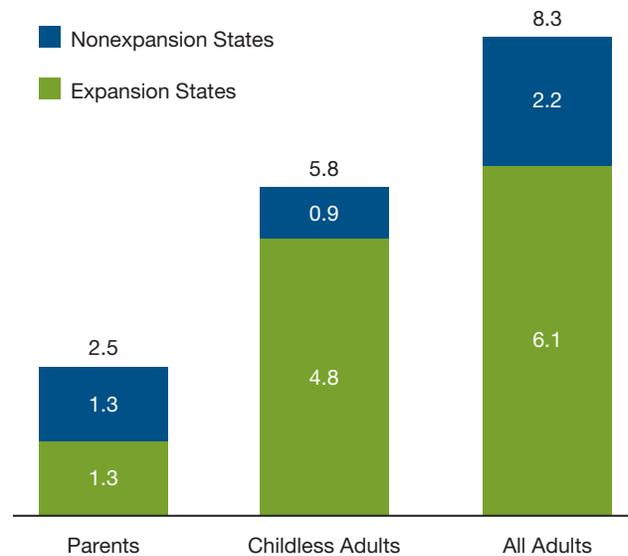
percent in 2013 and 75.7 percent in 2014), but participation in expansion states was lower in 2014 (67.0 percent) than in 2013 (76.5 percent), likely reflecting the much higher number of eligible childless adults in 2014 in these states, only some of whom enrolled in their first year of eligibility.

Eligible Uninsured Parents and Childless Adults, 2014. In 2014, an estimated 8.3 million uninsured adults were eligible for Medicaid but were not enrolled (Figure 4). Childless adults constituted the majority of these adults (5.8 million), most of whom (4.8 million) lived in expansion states. Many of these childless adults were newly eligible under the ACA. Parents constituted the remainder, with 2.5 million found to be eligible but uninsured in 2014, equally divided between expansion and nonexpansion states.

The estimated number of eligible uninsured adults in 2014 was nearly double the number in 2013 because of the large increase in eligibility in 2014 without a commensurate increase in participation (Table 2). The number of eligible uninsured parents increased somewhat from 2.1 million in 2013 to 2.5 million in 2014. Not surprisingly, given the large estimated increase in eligibility in expansion states, the number of eligible uninsured childless adults in expansion states rose from 1.3 million to 4.8 million, but remained relatively stable in nonexpansion states. These estimates indicate considerable potential for further reductions in uninsurance among poor and near poor adults, particularly childless adults, as the ACA Medicaid expansion matures. Uninsured adults are more likely to be eligible for Medicaid in expansion states than in nonexpansion states: fully 46.3 percent of uninsured childless adults and 34.3 percent of uninsured parents in expansion states were eligible for Medicaid, compared with just 7.5 percent and 24.7 percent, respectively, in nonexpansion states (Figure 5).

Parents' Medicaid Participation across States, 2014. Medicaid participation rates among parents in 2014 varied widely across states, ranging from 48.4 percent in Texas to 95.9 percent in the District of Columbia (Figure 6). In 2014, four states (District of Columbia, Massachusetts, Rhode Island, and Vermont) had participation rates for Medicaid-eligible parents above 90 percent, and another nine (Connecticut, Delaware, Hawaii, Maine, Maryland, Minnesota, New York, Ohio, and Wisconsin) had participation rates of between 80 and 90 percent. Of the 13 states with rates of 80 percent or higher, all but Maine and Wisconsin had expanded Medicaid under the ACA by June 2014, and all had some level of parent expansion pre-ACA through waivers or early ACA expansion options. In contrast, 10 nonexpansion states with relatively low levels of eligibility for parents in both 2013 and 2014 (Alabama,

Figure 4. Number (in millions) of Nonelderly Uninsured Medicaid-Eligible Adults, by Parental Status and State Expansion Status, 2014



Source: Urban Institute tabulations of 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS)

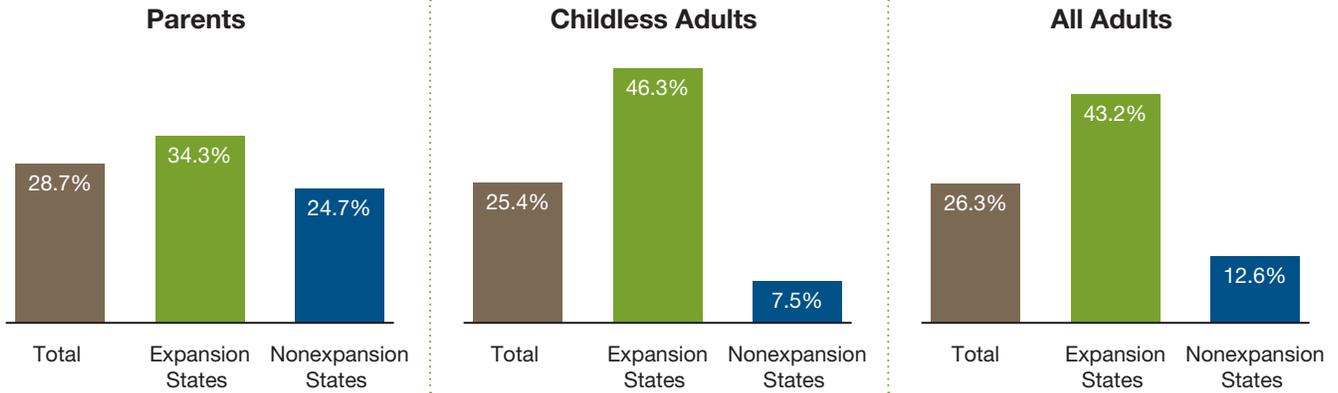
Notes: See text for how eligibility and uninsurance are defined. Estimates reflect microdata edits for probable misclassified coverage on the ACS. Nonelderly adults are defined as ages 19 to 64.

Alaska, Georgia, Kansas, Louisiana, Missouri, Oklahoma, South Dakota, Texas, and Wyoming) had participation rates below 60 percent.

Estimated participation rates were 16.4 percentage points higher in expansion states than in nonexpansion states. Only two nonexpansion states (Maine and Wisconsin) had higher participation in 2014 than the average rate for expansion states. These two states offered coverage to more parents than other nonexpansion states, with 2014 eligibility thresholds for parents in Maine and Wisconsin of 105 percent and 100 percent of FPL, respectively, much higher than for most other nonexpansion states (Heberlein, Brooks, Artiga, and Stephens 2013). The gap between expansion and nonexpansion states was even higher in 2014 than it was in 2013: participation was at 75.5 percent in expansion states and 65.1 percent in nonexpansion states in 2013 (Table 2).

Participation across States and among Pre-ACA Eligible Versus Newly Eligible Parents, 2013 and 2014. Medicaid participation among eligible parents grew or held relatively steady between 2013 and 2014 in every expansion state, with participation growing by over 10 percentage points

Figure 5. Share of Nonelderly Uninsured Adults Who Are Medicaid-Eligible, by Parental Status and State Expansion Status, 2014



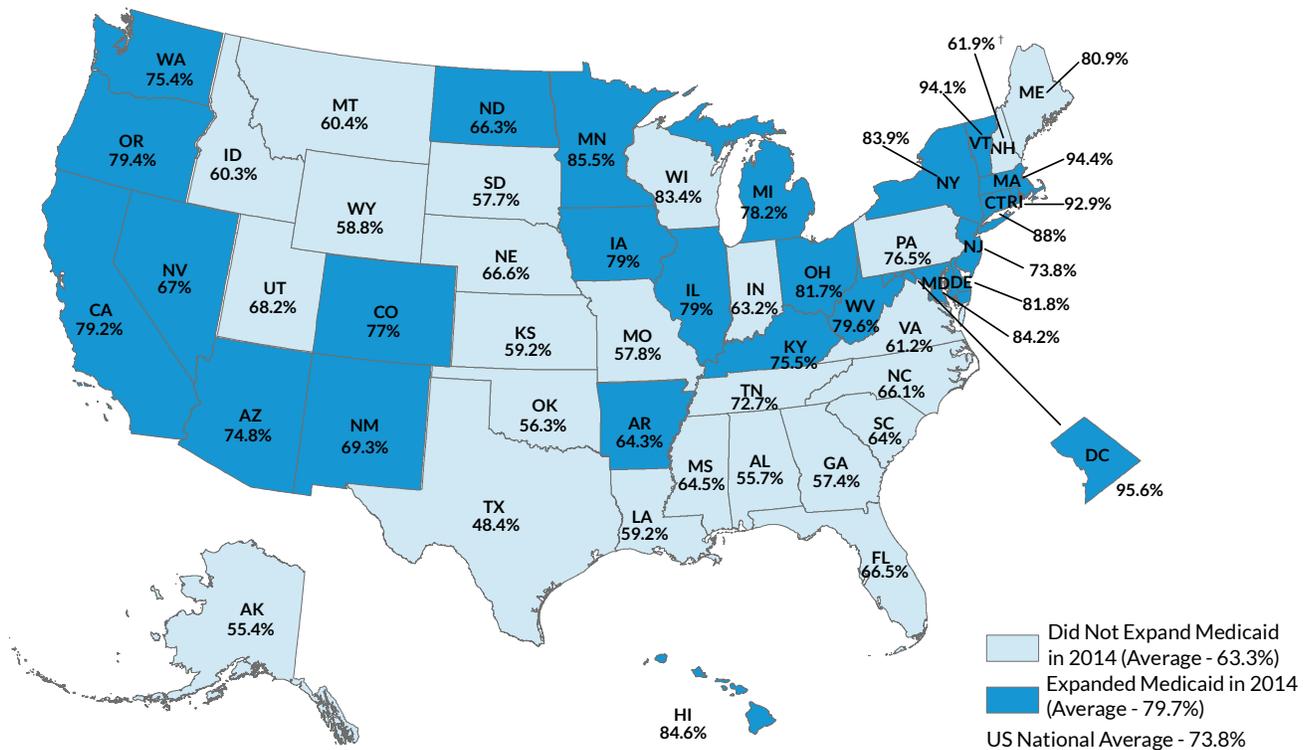
Source: Urban Institute tabulations of 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS)

Notes: See text for how eligibility and uninsurance are defined.

Estimates reflect microdata edits for probable misclassified coverage on the ACS.

Nonelderly adults are defined as ages 19 to 64.

Figure 6. Medicaid Participation Among Parents, by State, 2014



Source: Urban Institute tabulations of 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS).

Notes: See text for how eligibility and participation are defined.

† Since New Hampshire expanded Medicaid after mid-2014, it is included as a nonexpansion state in this analysis.

in Kentucky, Minnesota, Nevada, Rhode Island, and Washington State and holding relatively steady in states such as Michigan, Ohio, and Oregon (Table 3). In contrast, parents' participation fell by an average of 1.8 percentage points among nonexpansion states, with states such as Montana experiencing an increase (14.4 percent) and other states such as Missouri and Virginia seeing decreases (12.9 percent and 8.6 percent, respectively).

When classifying eligible parents in expansion states in 2014 according to whether they were modeled to be eligible before 2014 or were newly eligible as defined by the ACA, we find higher participation among pre-ACA eligible parents than newly eligible parents in every expansion state. That newly eligible parents had lower participation rates in 2014 than already eligible adults is not surprising, because 2014 was the first year of eligibility for these adults, and previously eligible adults had relatively high participation rates in 2013. Overall, we find an estimated gap in participation between pre-ACA eligible parents and newly eligible parents of 12.9 percentage points (84.3 percent compared with 71.4 percent), with even larger gaps between pre-ACA and newly eligible groups in states such as Arkansas, Nevada, and North Dakota (which had low eligibility levels and low participation rates before 2014, and where the ACA represents a large extension of eligibility to newly eligible adults). As these data reflect the first year of eligibility for newly eligible parents, we expect this gap will narrow as the expansion matures and participation among newly eligible parents increases.

Under the ACA, participation rates for already eligible parents increased by 8.9 percentage points on average and, at 84.3 percent, came closer to the participation rates for children, which were estimated to be 88.7 percent in 2013 and 91.0 percent in 2014 (Kenney et al. 2016). Participation among already eligible parents grew by an even larger margin in some states, with increases of greater than 20 percentage points in four states (Arkansas, Kentucky, Nevada, and Washington State).

Parents' Uninsurance and Medicaid Coverage across States, 2013 and 2014. The increases in participation among Medicaid-eligible parents, along with other ACA provisions such as the tax credits for coverage in the new health insurance marketplaces and the individual coverage requirement, were associated with declines in uninsurance and increases in Medicaid coverage among parents between 2013 and 2014 (Table 4). In 2013, uninsurance rates for parents were already higher in nonexpansion states (20.6 percent) than expansion states (14.9 percent), and Medicaid coverage rates were lower in nonexpansion states (10.8 percent) than expansion states (15.5 percent). On average,

larger declines in uninsurance and gains in Medicaid in expansion states compared with nonexpansion states further widened the gap between these two groups of states.

No state experienced a statistically significant increase in uninsurance among parents between 2013 and 2014, and there were significant declines in almost every state, with declines above 5 percentage points in Arkansas, California, Kentucky, Montana, Nevada, New Mexico, Oregon, Washington, and West Virginia. Of these states, only Montana did not expand Medicaid in 2014. Corresponding to the large observed drops in uninsurance, these states also saw notable increases in Medicaid coverage. By 2014, 16.5 percent of parents were covered by Medicaid, with rates ranging from 5.7 percent in Wyoming to 34.4 percent in the District of Columbia. Building on the estimated 8.3 million parents with Medicaid coverage in 2013, an additional 1.1 million parents were covered by Medicaid in 2014 than in 2013, with almost all of this growth (964,000) found in expansion states. As a result, the total number of parents estimated to have Medicaid reached 9.4 million in 2014, with 6.1 million of these parents in expansion states and 3.3 million in nonexpansion states.

The state with the largest drop in uninsurance among parents, Kentucky, which cut its uninsurance rate among all parents by 8.5 percentage points, was also one of the states with the largest increases (8.3 percentage points) in the share of parents covered by Medicaid. States with very small changes tended to be states with uninsurance rates for parents that were already quite low before 2014, such as the District of Columbia and Massachusetts, both of which had uninsurance for parents below 5 percent before 2014. In 2014, uninsurance rates for parents ranged from under 5 percent in three expansion states (Hawaii, Massachusetts, and Vermont) to over 20 percent in three nonexpansion states (Florida, Georgia, and Texas). Nine of the 10 states with the lowest uninsurance rates for parents were Medicaid expansion states, and eight of the 10 states with the highest uninsurance rates were nonexpansion states (the other two, Nevada and New Mexico, were the expansion states with the highest uninsurance rates in 2013).

The larger declines in parents' uninsurance rates in expansion states between 2013 and 2014 widened the gap between expansion states and nonexpansion states by 17.5 percent: uninsurance rates remained lower in expansion states (11.1 percent on average, ranging from 2.8 percent in Massachusetts to 19.5 percent in New Mexico) than in nonexpansion states (17.9 percent on average, ranging from 7.5 percent in Wisconsin to 26.4 percent in Texas) in 2014. Overall, the gains in coverage between 2013 and 2014 reduced differences in uninsured

Table 3. Medicaid Participation Among Parents, by State, State Expansion Status, and Eligibility Status, 2013 and 2014

	2013	2014		Difference			
	Total	Total	Pre-ACA Eligible	Newly Eligible	2014 Total Versus 2013	Pre-ACA Eligible Versus 2013	Pre-ACA Eligible Versus Newly Eligible
U.S. Total	71.7%	73.8%	--	--	2.1% **	--	--
Expanded Medicaid in 2014	75.5% ++	79.7% ++	84.3%	71.4%	4.2% **	8.9%	-12.9%
Arizona	69.5% ++	74.8%	78.1%	66.4%	5.2% **	8.6%	-11.7%
Arkansas	59.1% ++	64.3% ++	79.8%	57.6%	5.2% **	20.7%	-22.2%
California	72.8% ++	79.2% ++	82.4%	72.1%	6.4% **	9.6%	-10.3%
Colorado	70.8%	77.0% ++	81.4%	74.4%	6.2% **	10.6%	-7.0%
Connecticut	80.9% ++	88.0% ++	88.1%	87.1%	7.1% **	7.2%	-1.0%
Delaware	80.6% ++	81.8% ++	82.6%	78.4%	1.2% **	2.0%	-4.2%
District of Columbia	92.8% ++	95.6% ++	96.3%	86.4%	2.8% **	3.5%	-9.9%
Hawaii	75.0%	84.6% ++	84.9%	84.1%	9.6% **	9.9%	-0.8%
Illinois	76.6% ++	79.0% ++	80.1%	73.2%	2.4% **	3.5%	-7.0%
Iowa	75.9% +	79.0% ++	89.8%	72.2%	3.1% **	13.9%	-17.6%
Kentucky	61.5% ++	75.5% +	86.5%	69.6%	14.0% **	25.0%	-16.9%
Maryland	78.7% ++	84.2% ++	85.2%	80.5%	5.5% **	6.5%	-4.8%
Massachusetts	91.8% ++	94.4% ++	94.6%	93.0%	2.6% **	2.7%	-1.6%
Michigan	78.9% ++	78.2% ++	85.5%	70.7%	-0.7% **	6.6%	-14.8%
Minnesota	72.5%	85.5% ++	88.5%	78.8%	13.0% **	16.1%	-9.7%
Nevada	53.4% ++	67.0% ++	80.9%	62.5%	13.6% **	27.6%	-18.4%
New Jersey	69.6% ++	73.8%	79.3%	71.7%	4.2% **	9.7%	-7.7%
New Mexico	65.2% ++	69.3% ++	78.4%	64.4%	4.1% **	13.2%	-14.0%
New York	81.4% ++	83.9% ++	85.5%	70.2%	2.4% **	4.1%	-15.4%
North Dakota	62.4% ++	66.3% ++	79.1%	54.7%	3.9% **	16.7%	-24.4%
Ohio	81.0% ++	81.7% ++	87.5%	69.5%	0.7% **	6.5%	-18.0%
Oregon	78.2% ++	79.4% ++	86.1%	76.5%	1.1% **	7.9%	-9.6%
Rhode Island	75.8%	92.9% ++	94.5%	83.8%	17.1% **	18.7%	-10.7%
Vermont	87.2% ++	94.1% ++	99.2%	92.8%	6.9% **	12.0%	-6.4%
Washington	62.2% ++	75.4% +	82.7%	71.3%	13.2% **	20.5%	-11.4%
West Virginia	74.3%	79.6% ++	91.4%	74.0%	5.3% **	17.1%	-17.4%

(continued)

Table 3. Medicaid Participation Among Parents, by State, State Expansion Status, and Eligibility Status, 2013 and 2014 (continued)

	2013	2014		Difference			
	Total	Total	Pre-ACA Eligible	Newly Eligible	2014 Total Versus 2013	Pre-ACA Eligible Versus 2013	Pre-ACA Eligible Versus Newly Eligible
Did Not Expand Medicaid in 2014	65.1% ++	63.3% ++	--	--	-1.8%	--	--
Alabama	60.7% ++	55.7% ++	--	--	-5.0% *	--	--
Alaska	54.6% ++	55.4% ++	--	--	0.9% **	--	--
Florida	62.0% ++	66.5% ++	--	--	4.5% **	--	--
Georgia	55.2% ++	57.4% ++	--	--	2.2%	--	--
Idaho	66.9%	60.3% ++	--	--	-6.6%	--	--
Indiana	69.3%	63.2% ++	--	--	-6.1% **	--	--
Kansas	60.3% ++	59.2% ++	--	--	-1.1%	--	--
Louisiana	63.1% ++	59.2% ++	--	--	-3.9% **	--	--
Maine	82.3% ++	80.9% ++	--	--	-1.4%	--	--
Mississippi	69.4%	64.5% ++	--	--	-4.9% **	--	--
Missouri	70.7%	57.8% ++	--	--	-12.9% **	--	--
Montana	46.0% ++	60.4% ++	--	--	14.4% **	--	--
Nebraska	67.3%	66.6% ++	--	--	-0.7%	--	--
New Hampshire [†]	70.2%	61.9% ++	--	--	-8.3%	--	--
North Carolina	62.6% ++	66.1% ++	--	--	3.5% **	--	--
Oklahoma	54.7% ++	56.3% ++	--	--	1.6%	--	--
Pennsylvania	76.6% ++	76.5% ++	--	--	-0.1%	--	--
South Carolina	59.7% ++	64.0% ++	--	--	4.4% **	--	--
South Dakota	66.5%	57.7% ++	--	--	-8.8%	--	--
Tennessee	72.7% ++	72.7%	--	--	0.0%	--	--
Texas	51.4% ++	48.4% ++	--	--	-3.0% **	--	--
Utah	65.5% ++	68.2% ++	--	--	2.7%	--	--
Virginia	69.8%	61.2% ++	--	--	-8.6% **	--	--
Wisconsin	81.6% ++	83.4% ++	--	--	1.8%	--	--
Wyoming	57.5% ++	58.8% ++	--	--	1.3%	--	--

Source: Urban Institute tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS)

Notes: See text for how eligibility and participation are defined.

Estimates reflect microdata edits for probable misclassified coverage on the ACS.

Nonelderly adults are defined as ages 19 to 64.

[†] Since New Hampshire expanded Medicaid after mid-2014, it is included as a nonexpansion state in this analysis.

**/* Estimate differs significantly from 2013 estimate at the .05/.1 levels.

++/+ Estimate differs significantly from national average at the .05/.1 levels.

Table 4. Uninsurance and Medicaid Coverage Among Parents, by State and State Expansion Status, 2013 and 2014

	Uninsurance (%)			Medicaid Coverage (%)			Medicaid Coverage (1,000s)		
	2013	2014	Change	2013	2014	Change	2013	2014	Change
U.S. Total	17.6%	14.3%	-3.3% **	13.3%	16.5%	3.2% **	8,261	9,369	1,108
Expanded Medicaid in 2014	14.9% ++	11.1% ++	-3.8% **	15.5% ++	18.5% ++	3.0% **	5,121	6,085	964
Arizona	20.4% ++	16.5% ++	-3.9% **	17.3% ++	19.7% ++	2.4% **	216	247	31
Arkansas	23.7% ++	16.7% ++	-7.0% **	10.8% ++	17.4%	6.6% **	62	98	36
California	20.2% ++	14.7% ++	-5.5% **	15.2% ++	19.6% ++	4.3% **	1,171	1,512	341
Colorado	16.0% ++	12.8% ++	-3.3% **	11.8% ++	15.1% ++	3.3% **	128	166	38
Connecticut	8.4% ++	6.5% ++	-2.0% **	16.7% ++	18.8% ++	2.1% **	119	131	12
Delaware	11.9% ++	8.1% ++	-3.9% **	18.7% ++	16.8%	-1.9%	31	28	-3
District of Columbia	4.4% ++	5.0% ++	0.5%	34.9% ++	34.4% ++	-0.5%	31	28	-3
Hawaii	6.9% ++	4.2% ++	-2.7% **	12.8%	15.3%	2.5% **	31	39	8
Illinois	13.0% ++	11.1% ++	-2.0% **	16.6% ++	17.3% ++	0.7% **	429	444	15
Iowa	10.7% ++	7.1% ++	-3.7% **	11.4% ++	13.7% ++	2.4% **	73	90	17
Kentucky	18.9% ++	10.4% ++	-8.5% **	11.5% ++	19.7% ++	8.3% **	99	172	72
Maryland	10.6% ++	8.6% ++	-2.1% **	11.6% ++	14.4% ++	2.9% **	137	169	32
Massachusetts	3.4% ++	2.8% ++	-0.6% **	19.8% ++	20.6% ++	0.8% *	257	266	9
Michigan	12.1% ++	8.7% ++	-3.5% **	16.6% ++	18.7% ++	2.1% **	315	354	39
Minnesota	8.3% ++	5.6% ++	-2.7% **	13.2%	17.0%	3.8% **	147	188	41
Nevada	24.5% ++	18.7% ++	-5.8% **	8.1% ++	13.8% ++	5.7% **	44	71	28
New Jersey	14.7% ++	11.7% ++	-2.9% **	10.9% ++	12.8% ++	1.9% **	205	234	29
New Mexico	26.9% ++	19.5% ++	-7.4% **	18.6% ++	22.3% ++	3.7% **	72	84	12
New York	11.5% ++	10.0% ++	-1.5% **	21.5% ++	22.1% ++	0.6% **	796	801	5
North Dakota	10.6% ++	9.6% ++	-0.9% **	9.0% ++	10.9% ++	2.0% **	13	16	3
Ohio	10.3% ++	7.7% ++	-2.6% **	17.8% ++	19.4% ++	1.6% **	398	430	32
Oregon	17.7%	12.2% ++	-5.5% **	13.6%	21.0% ++	7.3% **	103	156	52
Rhode Island	11.3% ++	7.2% ++	-4.1% **	18.4% ++	22.4% ++	4.0% **	35	43	8
Vermont	5.8% ++	4.3% ++	-1.5% *	28.1% ++	26.5% ++	-1.6%	31	31	0
Washington	18.1%	11.1% ++	-7.0% **	9.4% ++	14.9% ++	5.6% **	132	207	74
West Virginia	16.9%	10.1% ++	-6.7% **	14.0%	25.1% ++	11.1% **	46	81	35

(continued)

Table 4. Uninsurance and Medicaid Coverage Among Parents, by State and State Expansion Status, 2013 and 2014 (continued)

	Uninsurance (%)			Medicaid Coverage (%)			Medicaid Coverage (1,000s)		
	2013	2014	Change	2013	2014	Change	2013	2014	Change
Did Not Expand Medicaid in 2014	20.6% ++	17.9% ++	-2.8% **	10.8% ++	11.3% ++	0.5% **	3,140	3,283	144
Alabama	18.9% ++	16.9% ++	-2.0% **	10.7% ++	11.0% ++	0.3%	100	96	-4
Alaska	19.3%	17.8% ++	-1.5%	9.0% ++	13.8% ++	4.8% **	13	20	7
Florida	24.8% ++	20.6% ++	-4.1% **	13.7% ++	14.5% ++	0.8% **	452	480	28
Georgia	23.3% ++	20.3% ++	-3.0% **	8.5% ++	10.0% ++	1.5% **	170	206	36
Idaho	21.5% ++	18.9% ++	-2.6% **	8.9% ++	9.2% ++	0.3%	32	31	0
Indiana	17.3%	15.1% ++	-2.1% **	11.5% ++	11.3% ++	-0.1%	152	148	-4
Kansas	17.3%	14.7%	-2.6% **	6.7% ++	7.8% ++	1.1% **	41	47	6
Louisiana	21.0% ++	18.6% ++	-2.3% **	11.8% ++	11.8% ++	-0.1%	104	100	-3
Maine	10.1% ++	10.0% ++	-0.2%	25.2% ++	23.9% ++	-1.4%	57	55	-2
Mississippi	19.7% ++	18.2% ++	-1.5% **	16.0% ++	14.5% ++	-1.4% **	90	81	-9
Missouri	15.9% ++	15.0% ++	-0.9% *	11.2% ++	9.1% ++	-2.1% **	132	107	-26
Montana	24.0% ++	16.0% +	-8.0% **	8.6% ++	11.9% ++	3.4% **	16	23	7
Nebraska	14.3% ++	12.2% ++	-2.1% **	8.0% ++	8.4% ++	0.4%	31	33	2
New Hampshire [†]	11.7% ++	10.3% ++	-1.4%	7.9% ++	8.6% ++	0.8%	21	22	1
North Carolina	20.8% ++	17.5% ++	-3.3% **	10.6% ++	12.1% ++	1.5% **	200	232	32
Oklahoma	24.4% ++	19.4% ++	-5.0% **	10.6% ++	11.2% ++	0.6%	81	86	4
Pennsylvania	11.6% ++	10.1% ++	-1.5% **	12.2% ++	12.4% ++	0.2%	288	290	2
South Carolina	19.2% ++	17.1% ++	-2.1% **	13.4%	14.2% ++	0.8%	118	121	3
South Dakota	14.2% ++	11.3% ++	-2.9% **	8.5% ++	7.2% ++	-1.3%	14	12	-2
Tennessee	16.4% ++	13.0% ++	-3.4% **	16.7% ++	19.4% ++	2.7% **	209	248	38
Texas	30.6% ++	26.4% ++	-4.2% **	7.5% ++	7.9% ++	0.5% **	425	458	33
Utah	15.9% ++	13.9%	-2.0% **	7.7% ++	8.4% ++	0.7%	54	59	5
Virginia	14.3% ++	13.1% ++	-1.2% **	7.5% ++	7.7% ++	0.2%	121	127	6
Wisconsin	7.5% ++	7.5% ++	0.0%	18.6% ++	17.0%	-1.6%	212	194	-18
Wyoming	16.3%	12.4% +	-3.9% **	5.5% ++	5.7% ++	0.2%	7	7	0

Source: Urban Institute tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS)

Notes: See text for how insurance coverage is defined.

Estimates reflect microdata edits for probable misclassified coverage on the ACS.

Nonelderly adults are defined as ages 19 to 64.

[†] Since New Hampshire expanded Medicaid after mid-2014, it is included as a nonexpansion state in this analysis.

**/* Estimate differs significantly from 2013 estimate at the .05/.1 levels.

+ +/+ Estimate differs significantly from national average at the .05/.1 levels.

rates across states, narrowing the range of state-level uninsurance rates from 27.1 percentage points in 2013 to 23.5 percentage points in 2014. Massachusetts and Texas were the states with the lowest and highest uninsured rates, respectively, among parents in both years.

Childless Adults' Uninsurance and Medicaid Coverage across States, 2013 and 2014. Although we do not examine changes in Medicaid participation rates among childless adults across states,¹¹ estimated rates of Medicaid coverage increased significantly in almost every expansion state and in some nonexpansion states, and uninsurance fell for childless adults by a statistically significant margin between 2013 and 2014 in almost every state. Uninsurance among childless adults in nonexpansion states fell by an average of 4.1 percentage points, dropping by less than a percentage point in Wyoming and by over 5 percentage points in Florida and South Dakota. The average uninsurance rate in nonexpansion states in 2014 was 20.5 percent, similar to the average level in expansion states in 2013. However, uninsurance fell more for childless adults in expansion states in 2014, reaching 15.0 percent. Declines ranged from under 2 percentage points in Massachusetts

(which had a very low uninsurance rate before 2014) to over 9 percentage points in Kentucky and Oregon.

In 2014, uninsurance rates for childless adults ranged from 5.5 percent in Massachusetts to above 25 percent in Texas and Florida. All of the 10 states with the lowest uninsurance rates for childless adults were expansion states, and eight of the 10 states with the highest uninsurance rates were nonexpansion states. Medicaid coverage rates among childless adults in 2014 ranged from below 6.0 percent in three nonexpansion states (New Hampshire, Utah, and Virginia) to 20 percent or more in six expansion states (District of Columbia, Kentucky, Massachusetts, New Mexico, Oregon, and Vermont). In that year, an estimated 16.9 million childless adults were enrolled in comprehensive Medicaid coverage, growing by 4.4 million from 2013, with almost all of the growth in expansion states. Because most states did not offer any income-based Medicaid eligibility to childless adults before the ACA, much of this enrollment is likely to be among newly eligible adults. Of the estimated 16.9 million childless adult Medicaid enrollees in 2014, 11.7 million lived in expansion states and 5.2 million lived in nonexpansion states.

DISCUSSION

During the first year of implementation of the major coverage provisions of the ACA, including Medicaid expansion in 26 states, we find that an estimated seven out of 10 eligible adults without other coverage participated in the program, with 26.3 million nonelderly adults having Medicaid coverage at the time of the survey. Another 31.5 million adults were uninsured; of these, an estimated 8.3 million were eligible for Medicaid but were not enrolled.

Between 2013 and 2014, Medicaid enrollment among nonelderly adults rose, with 1.1 million additional parents and 4.4 million additional childless adults enrolled in Medicaid in 2014 than in 2013. Furthermore, an estimated 8.4 million fewer adults were uninsured in 2014 than in 2013, including 2.1 million fewer parents and 6.4 million fewer childless adults. The uninsurance rate among adults fell from 17.6 percent to 14.3 percent, representing the largest decline in uninsurance observed among nonelderly adults since the ACS began collecting coverage status in 2008. Although uninsurance rates fell between 2013 and 2014 for both parents and childless adults in almost every state, declines in uninsurance were greater and Medicaid coverage gains were larger in states participating in the ACA's Medicaid expansion, suggesting that expansion status and other associated policy differences related to ACA implementation may be contributing to variation across groups of states.

Notably, changes between 2013 and 2014 further widened differences in Medicaid eligibility and coverage between expansion and nonexpansion states. These findings are confirmed by higher Medicaid enrollment growth in expansion states as compared with nonexpansion states (CMS 2016).¹² Although there are methodological challenges when making comparisons between 2013 and 2014, this analysis also indicates increasing Medicaid participation among parents in most expansion states, consistent with the outreach investments and simplification measures put in place under the ACA. Although the direction of the coverage changes observed was consistent across almost all expansion states, these estimates also suggest considerable heterogeneity in changes in uninsurance, with states such as the District of Columbia and Massachusetts (which had low uninsurance before 2014 because of earlier expansions) holding relatively steady and states such as Kentucky and New Mexico (which had higher than average uninsurance rates in 2013) experiencing declines in parents' uninsurance of more than 7 percentage points.

Participation in Medicaid among eligible adults appears to be higher in 2014 than it was in 2009 (Kenney, Lynch, Haley, and Huntress 2012).¹³ Experience from prior extensions of public coverage among children and adults suggests that enrollment lags behind eligibility expansions (Kenney

et al. 2015; Sommers et al. 2013). Data from 2014 reflect very early stages of implementation of the ACA coverage provisions, and although policies such as the delaying of Medicaid renewals to give states time to address systems issues and the use of targeted enrollment strategies may have had positive impacts on Medicaid participation in 2014 (CMS 2014b), some states were dealing with backlogs in application processing, enrollment system failures, and problems with data transfers between federal and state systems that may have hindered participation. Furthermore, five additional states have implemented the Medicaid expansion since mid-2014; additional adults were enrolled in Medicaid and marketplace coverage since these data were collected; state difficulties related to ACA implementation that affected Medicaid enrollment in 2014 have been subsequently resolved; and by 2015, all states had seen Medicaid enrollment increases since the third quarter of 2013 (CMS 2016; Kaiser Family Foundation 2016). Thus, patterns of eligibility and participation have likely shifted since 2014. Analysis of survey data from early 2015 (Blumberg et al. 2016) suggests that the number of eligible uninsured adults was lower than found in this analysis of data from throughout 2014.

The ACA also appears to be having a positive impact on children's coverage, which could be, in part, related to changes described here for parents, as well as to the new health insurance marketplaces, the individual coverage requirement, and other provisions. For example, as parents shopped for plans in the new health insurance marketplaces, their children were to be screened for potential Medicaid and Children's Health Insurance Program (CHIP) eligibility. The estimated uninsurance rate for children age 18 and under declined from 7.0 percent in 2013 to 5.8 percent in 2014, with an accompanying decline in the number of eligible uninsured children (Kenney et al. 2016). Eligibility for public coverage remains much more extensive for children, with a median eligibility threshold of 255 percent of FPL in 2014, higher than for adults even in expansion states.

Medicaid participation rates for adults have historically lagged behind those for children, and that pattern continued in 2014. Children had Medicaid/CHIP participation rates of 92.9 percent and 89.0 percent in expansion and nonexpansion states in 2014, respectively. The comparable rates for parents were 79.7 percent and 63.3 percent, indicating that many additional eligible uninsured parents could be reached through their children's enrollment in Medicaid/CHIP. In addition, the gap in participation between children and parents was larger in nonexpansion states,

which suggests that both expansion and nonexpansion states could enroll more eligible parents by reaching out to those who have children enrolled (CMS 2014b; Heberlein et al. 2012). There is even more room to raise participation rates among childless adults, potentially by reaching out to those participating in other public programs such as the Earned Income Tax Credit or the Supplemental Nutrition Assistance Program (Blumberg et al. 2016).

The findings on increased Medicaid enrollment among pre-ACA eligible adults in 2014 could be taken as evidence of a welcome mat or woodwork effect, in which Medicaid take-up among already eligible adults increased under ACA implementation in response to expanded outreach and awareness of coverage options and simplified enrollment processes (Frea, Gruber, and Sommers 2016). However, overall these data suggest that enrollment increases seem to be concentrated among newly eligible adults in expansion states. Although we find that enrollment rose among adults in nonexpansion states, this increase may not be directly attributed to the woodwork effect, as some additional enrollment in 2014 in nonexpansion states may be occurring among those made newly eligible because of the change in the way eligibility was determined in 2014. Given that nonexpansion states have lower average pre-ACA eligibility levels relative to expansion states (Heberlein, Brooks, Alker, et al. 2013; McMorrow et al. 2016), they likely would also experience a smaller welcome mat effect if they were to expand. In addition, despite the apparent increase in Medicaid take-up among already eligible parents, states with large increases in enrollment among already eligible parents, such as Kentucky and Washington, are among those states finding budget savings under the ACA (Bachrach et al. 2016; Dorn et al. 2015). An analysis of 14 Medicaid expansion states that have comprehensively analyzed the state budgetary effects of Medicaid expansion finds net savings to the states, with savings projected to 2020 and later years for most of these states (Dorn and Buettgens 2016).

Because the majority of eligible uninsured adults live in expansion states, higher Medicaid enrollment levels in these states could further reduce national uninsurance rates. Although some uninsured parents and childless adults are eligible for Medicaid in nonexpansion states, others fall into the "assistance gap," having incomes above their state's Medicaid eligibility levels but too low to qualify for subsidized marketplace coverage (Blumberg et al. 2016; Buettgens and Kenney 2016). For these uninsured adults, access to affordable health insurance coverage likely hinges on their state's electing to participate in the ACA's Medicaid expansion.

Table 5. Uninsurance and Medicaid Coverage Among Childless Adults, by State and State Expansion Status, 2013 and 2014

	Uninsurance (%)			Medicaid Coverage (%)			Medicaid Coverage (1,000s)		
	2013	2014	Change	2013	2014	Change	2013	2014	Change
U.S. Total	22.7%	17.5%	-5.2% **	9.8%	13.1%	3.3% **	12,523	16,903	4,380
Expanded Medicaid in 2014	21.1% ++	15.0% ++	-6.1% **	10.9% ++	16.7% ++	5.8% **	7,556	11,678	4,122
Arizona	26.4% ++	19.6% ++	-6.8% **	10.3% ++	16.5% ++	6.2% **	265	427	162
Arkansas	25.3% ++	18.3% ++	-7.0% **	10.2%	16.9% ++	6.8% **	116	194	78
California	27.1% ++	18.9% ++	-8.2% **	10.6% ++	18.1% ++	7.4% **	1,672	2,888	1,215
Colorado	20.9% ++	14.9% ++	-6.0% **	6.7% ++	13.8% ++	7.2% **	143	302	159
Connecticut	16.3% ++	11.0% ++	-5.3% **	11.1% ++	16.3% ++	5.2% **	163	242	79
Delaware	15.7% ++	11.0% ++	-4.7% **	14.3% ++	16.1% ++	1.8% **	55	62	7
District of Columbia	10.3% ++	7.6% ++	-2.8% **	17.7% ++	22.9% ++	5.2% **	63	85	22
Hawaii	12.4% ++	8.3% ++	-4.2% **	11.8% ++	13.0%	1.1% **	67	73	6
Illinois	21.4% ++	15.6% ++	-5.8% **	8.8% ++	13.0% ++	4.3% **	461	685	224
Iowa	14.3% ++	8.8% ++	-5.5% **	9.6% ++	13.9% ++	4.3% **	114	162	48
Kentucky	22.7%	13.5% ++	-9.2% **	10.4% ++	20.0% ++	9.6% **	184	352	168
Maryland	16.6% ++	12.3% ++	-4.3% **	8.6% ++	13.3%	4.7% **	211	332	121
Massachusetts	7.2% ++	5.5% ++	-1.6% **	17.0% ++	22.2% ++	5.1% **	488	645	158
Michigan	18.9% ++	13.9% ++	-5.0% **	12.1% ++	16.9% ++	4.8% **	490	685	196
Minnesota	12.8% ++	9.5% ++	-3.4% **	11.1% ++	15.4% ++	4.3% **	241	339	99
Nevada	29.2% ++	21.4% ++	-7.8% **	5.8% ++	11.7% ++	5.9% **	67	140	73
New Jersey	22.0% ++	17.6% ++	-4.3% **	7.1% ++	11.0% ++	3.9% **	253	398	145
New Mexico	29.5% ++	22.1% ++	-7.5% **	12.5% ++	20.3% ++	7.8% **	104	170	67
New York	17.8% ++	13.2% ++	-4.7% **	16.0% ++	19.9% ++	3.9% **	1,355	1,711	355
North Dakota	16.2% ++	10.6% ++	-5.6% **	4.5% ++	9.1% ++	4.6% **	13	27	14
Ohio	18.8% ++	13.6% ++	-5.3% **	10.0% +	14.6% ++	4.5% **	470	684	213
Oregon	24.3% ++	15.1% ++	-9.3% **	9.2% ++	20.5% ++	11.2% **	151	339	188
Rhode Island	19.4% ++	11.2% ++	-8.2% **	9.0%	19.0% ++	10.0% **	42	87	46
Vermont	11.8% ++	8.1% ++	-3.7% **	17.4% ++	21.3% ++	3.9% **	48	58	10
Washington	21.8% ++	13.8% ++	-8.0% **	7.8% ++	15.1% ++	7.3% **	222	438	216
West Virginia	22.2% ++	14.8% ++	-7.4% **	12.9% ++	19.7% ++	6.9% **	100	152	52

(continued)

Table 5. Uninsurance and Medicaid Coverage Among Childless Adults, by State and State Expansion Status, 2013 and 2014 (continued)

	Uninsurance (%)			Medicaid Coverage (%)			Medicaid Coverage (1,000s)		
	2013	2014	Change	2013	2014	Change	2013	2014	Change
Did Not Expand Medicaid in 2014	24.6% ++	20.5% ++	-4.1% **	8.4% ++	8.8% ++	0.4% **	4,967	5,225	258
Alabama	22.6%	19.2% ++	-3.3% **	9.7%	9.9% ++	0.2%	188	197	9
Alaska	26.4% ++	24.7% ++	-1.8%	6.5% ++	7.4% ++	0.9%	20	22	3
Florida	31.8% ++	25.7% ++	-6.1% **	8.4% ++	9.3% ++	0.8% **	683	764	81
Georgia	28.3% ++	23.3% ++	-5.0% **	7.6% ++	8.1% ++	0.5% **	302	324	23
Idaho	25.4% ++	20.0% ++	-5.5% **	7.5% ++	6.7% ++	-0.8%	43	39	-3
Indiana	20.7% ++	17.6% ++	-3.1% **	9.5% ++	8.8% ++	-0.7% **	244	229	-15
Kansas	18.6% ++	15.3% ++	-3.3% **	6.5% ++	6.7% ++	0.2%	69	72	3
Louisiana	27.1% ++	23.1% ++	-4.0% **	11.6% ++	11.4% ++	-0.2%	220	218	-2
Maine	19.0% ++	15.6% ++	-3.4% **	14.2% ++	13.7%	-0.5%	83	79	-4
Mississippi	28.1% ++	23.6% ++	-4.5% **	11.5% ++	12.5% ++	0.9% **	136	146	10
Missouri	20.4% ++	16.9% ++	-3.5% **	8.8% ++	8.4% ++	-0.4% *	213	203	-10
Montana	24.6% ++	21.1% ++	-3.5% **	7.1% ++	7.6% ++	0.5%	29	31	2
Nebraska	16.2% ++	14.4% ++	-1.9% **	5.8% ++	6.3% ++	0.5%	41	44	3
New Hampshire [†]	17.8% ++	14.3% ++	-3.5% **	7.2% ++	5.3% ++	-1.9% **	40	30	-10
North Carolina	24.8% ++	20.3% ++	-4.5% **	8.7% ++	9.2% ++	0.5% **	345	367	22
Oklahoma	25.0% ++	22.7% ++	-2.3% **	8.7% ++	7.2% ++	-1.6% **	129	106	-23
Pennsylvania	15.5% ++	13.0% ++	-2.6% **	10.4% ++	10.9% ++	0.5% **	553	582	29
South Carolina	25.2% ++	21.6% ++	-3.6% **	8.7% ++	9.5% ++	0.8% **	170	190	20
South Dakota	20.1% ++	14.7% ++	-5.4% **	7.0% ++	7.8% ++	0.8%	23	26	3
Tennessee	23.0% ++	19.7% ++	-3.3% **	9.6%	10.3% ++	0.7% **	254	271	17
Texas	30.2% ++	25.6% ++	-4.6% **	7.2% ++	7.4% ++	0.1%	720	751	31
Utah	20.4% ++	17.9%	-2.6% **	5.7% ++	5.8% ++	0.2%	54	57	3
Virginia	19.5% ++	16.1% ++	-3.3% **	5.9% ++	5.0% ++	-0.9% **	200	168	-32
Wisconsin	16.2% ++	11.5% ++	-4.8% **	8.5% ++	12.5% ++	4.0% **	198	290	92
Wyoming	20.1% ++	19.4% ++	-0.7%	4.2% ++	7.6% ++	3.4% **	10	18	8

Source: Urban Institute tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS)

Notes: See text for how insurance coverage is defined.

Estimates reflect microdata edits for probable misclassified coverage on the ACS.

Nonelderly adults are defined as ages 19 to 64.

[†] Since New Hampshire expanded Medicaid after mid-2014, it is included as a nonexpansion state in this analysis.

**/* Estimate differs significantly from 2013 estimate at the .05/.1 levels.

++/+ Estimate differs significantly from national average at the .05/.1 levels.

METHODOLOGICAL APPENDIX

American Community Survey. The American Community Survey (ACS) is an annual survey sponsored by the U.S. Census Bureau. We use an augmented version of the ACS, prepared by the University of Minnesota's Population Center, known as the Integrated Public Use Microdata Series (Ruggles et al. 2010). The survey had a household response rate of 89.9 percent in 2013 and 96.7 percent in 2014 (U.S. Census Bureau 2014). It uses an area frame that includes households with and without telephones (landline and cellular) and is a mixed-mode survey that can be completed by mail or (new for 2013) online, followed by telephone interviews for initial nonresponders and further followed by in-person interviews for remaining nonresponders. Estimates are weighted, and standard errors take into account the complex sample design of the survey. Our analysis uses the 2013 and 2014 ACS; each year of the public use sample includes over 1.8 million adults ages 19 to 64 in the civilian noninstitutionalized population.¹⁴ (We also examined levels of uninsurance before 2013 by using ACS data from 2008 through 2012.) The ACS is fielded continuously over the course of the year, so the estimates reported here reflect averages for 2013 and 2014, respectively. Estimates for 2014 reflect a very early look at changes following the expansion of Medicaid under the ACA; some states' expansions did not begin until after January (e.g., Michigan's expansion was not implemented until April 1, 2014, and New Hampshire's until August 15, 2014). Even for states with expansions in place as of January 1, 2014, it is anticipated that the full effects of expansion will not be felt for several years (Buettgens et al. 2013). In addition, enrollment has increased since 2014 (CMS 2016), and the ACA's impact on Medicaid coverage, eligibility, and participation is likely to change as the program matures.

Separate analyses are conducted for parents and childless adults; a parent is defined as an adult living in a household with a biological child, adoptive child, or stepchild under age 19. For simulating eligibility, we define parents according to eligibility rules and include relative caretakers as "parents" when appropriate. As a result, nonparent adults may be classified as eligible under relative caretaker provisions. However, these adults are not included with parents in the tables in this brief.

Measurement of Insurance Coverage. Coverage status, which was added to the ACS in 2008, is measured as an individual's point-in-time coverage at the time of the survey by using a single question asking about multiple coverage types. Estimates represent an annual average over the 12 months of the year in which the data were collected. Following prior

research, reported coverage through the Indian Health Service (IHS) is not counted as health insurance coverage because of limitations in the scope of available services and geographic reach of IHS facilities.¹⁵ This report provides estimates of uninsurance and Medicaid coverage, which is defined on the survey as "Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability" and includes comprehensive Medicaid, excluding single-service plans such as family-planning services only. The estimates provided in this report are based on respondents' reports of receiving only Medicaid or receiving Medicaid along with another type of coverage, such as a private plan or Medicare.

Although research suggests the ACS coverage estimates released by the U.S. Census Bureau are generally valid and are fairly consistent with those from other widely used national surveys, there are limitations to this question methodology and known measurement errors (Boudreaux et al. 2015). Therefore, this analysis uses edits that are applied if other information collected in the ACS implies that coverage for a sample case likely has been misclassified (Lynch et al. 2010, Lynch and Kenney 2013), drawing on approaches that have been applied to other surveys and primarily relying on simulated eligibility, income, coverage type, and family relationships for sample members and any family members. The rules target likely misclassified reported Medicaid and nongroup coverage, but they affect other coverage types as sample people are edited to and from other types of coverage. For nongroup coverage, the rules primarily move people from nongroup to another type of reported coverage if there is evidence that the other type is their primary coverage. For Medicaid, the rules rely on simulated eligibility to reclassify people as having comprehensive Medicaid or not, and they have been found to perform well in a study comparing ACS Medicaid and Children's Health Insurance Program (CHIP) data to administrative enrollment data (Lynch and Resnick forthcoming). The 2013 and 2014 edit rules differ because of changes to eligibility rules and pathways to coverage under the ACA; the 2014 rules were developed to be as similar as possible to those used for prior years while incorporating changes to align with policy shifts. For example, the edits incorporate the availability of subsidized marketplace coverage starting in 2014, using lower income thresholds to identify people who likely cannot afford nongroup coverage. Given the policy changes, it is likely impossible to edit consistently across the 2013 to 2014 period, which could introduce bias in our estimates of changes in coverage type over time.

Measurement of Medicaid Eligibility. To assess Medicaid eligibility, we use information about the person and family provided by survey respondents in combination with the Medicaid eligibility rules in place in each person's state of residence in the year in which respondents were surveyed (Brooks et al. 2015; Heberlein, Brooks, Alker, et al. 2013; Heberlein, Brooks, Artiga, et al. 2013).

For 2013, we use the Urban Institute Health Policy Center's Medicaid Eligibility Simulation Model, which estimates pre-ACA eligibility for Medicaid by using available information on eligibility guidelines, including the amount and extent of income disregards¹⁶ and asset tests, for each program and state as of mid-2013 (Lynch, Haley, and Kenney 2014). Our model identifies eligibility for comprehensive Medicaid or Medicaid-equivalent benefits by using state rules for major pathways for adults. The following eligibility pathways are modeled (they correspond roughly to the order in which caseworkers or state eligibility-determination software typically check for eligibility):

1. Aged-out foster children (young adults who were foster children who qualify for Medicaid)
2. Supplemental Security Income (SSI) (adults who receive SSI income are deemed Medicaid eligible because they are enrolled automatically in most states)
3. Section 1931 (usually parents of minors whose incomes fall below the Temporary Assistance for Needy Families income cutoffs)
4. Aged, blind, or disabled (adults with functional limitations who meet the qualifications for aged, blind, or disabled coverage)
5. Section 1115 waivers (adults who meet the qualifications for eligibility in states with Section 1115 programs that provide comprehensive Medicaid or Medicaid-equivalent benefits)
6. Medically needy (adults categorically eligible for medically needy coverage who meet the income qualifications for eligibility without taking into account out-of-pocket medical spending)
7. Relative caretakers (adults who are not parents of minors but appear to be relative caretakers of Medicaid-enrolled minors not living with their parents)

We include as eligible some adults who report having Medicaid coverage and categorically qualify for specific eligibility pathways but whose income is slightly above the

eligibility thresholds. However, this group is excluded from calculations of participation because we have no way to identify the eligible people who do not report Medicaid and are missed by our model. We also include as eligible in 2013 those who qualify for early ACA expansions in Connecticut, the District of Columbia, and Minnesota (although additional states such as California implemented early ACA expansions, we only include states with statewide, comprehensive early ACA expansions) (Heberlein, Brooks, Alker, et al. 2013). We exclude from eligibility those whom we classify as "limited benefit eligible," that is, adults who are ineligible for comprehensive Medicaid but eligible for federally funded Section 1115 Medicaid coverage (such as Commonwealth Care in Massachusetts) or state-funded coverage (such as the Basic Health Plan in Washington) that is more limited in scope than comprehensive Medicaid or is only available to adults in certain counties in a state, as opposed to statewide. Although some states adopted early conversion to modified adjusted gross income (MAGI) methodology for eligibility determination before 2014, we did not model these changes in eligibility determination for 2013.¹⁷

For 2014, we use the Health Insurance Policy Simulation Model—ACS version (HIPSM-ACS) (Buettgens 2011; Buettgens et al. 2013). HIPSM-ACS builds on the Medicaid Eligibility Simulation Model and applies rules as defined in the ACA and in guidance provided by the Centers for Medicare and Medicaid Services (CMS) that took effect in 2014, reflecting both the increase in eligibility to 138 percent of the federal poverty level (FPL) in participating states and the shift to MAGI-based eligibility determination procedures, including the elimination of asset tests. Eligibility was defined for both MAGI-exempt adults (such as those with disabilities) and MAGI-based adults using MAGI-converted thresholds from CMS. The conversion to MAGI-based eligibility determination involved changes in what income components were counted and which family members' income was included when comparing the family unit's income level to eligibility thresholds. In addition, the conversion of pre-ACA Medicaid eligibility thresholds to MAGI-equivalent thresholds under the ACA took into account pre-ACA rules and thresholds and incorporated the average effects of any state-specific income disregards, in addition to applying a flat 5 percentage point disregard to the highest income level covered within each group of beneficiaries (e.g., parents) (CMS 2014a, CMS 2013). MAGI conversion also eliminated the asset tests some states had applied for adults.

Certain pathways to eligibility, such as Transitional Medical Assistance, were eliminated, and multiple Medicaid eligibility

pathways—including Section 1931 and 1115 waivers, relative caretaker eligibility, eligibility for refugees, and option eligibility for pregnant women—were combined in a single MAGI threshold for parents and another for childless adults, even though the pre-ACA rules for these pathways varied considerably. As a result of these changes and the shifts in income rules, MAGI conversion and the new 5 percent disregard effectively increased Medicaid eligibility levels for some individuals even in states not participating in the ACA's Medicaid expansion, particularly for parents. Among the 25 nonexpansion states, the median pre-ACA upper threshold for parents was 31 percent of FPL (before applying any disregards) or 48 percent of FPL (after applying work disregards) in 2013, meaning thresholds effectively varied according to work status and other characteristics. In 2014, these eligibility levels were converted to MAGI-based thresholds, which took into account pre-ACA rules and thresholds as well as the average effects of any state-specific pre-ACA income disregards and incorporated a flat 5 percent disregard (Heberlein, Brooks, Alker, et al. 2013). The median threshold among these states was 47 percent of FPL in 2014, with variation across states. Under the ACA, each state has only one parent threshold and, where applicable, only one childless adult threshold for MAGI-based eligibility. This eliminates differences in eligibility caused by characteristics such as work status and differences in the eligibility rules for pre-ACA Medicaid eligibility pathways that were not MAGI-exempt. Thus, MAGI conversion could affect eligibility for individual adults, with some gaining and others losing eligibility. Eligibility for parents was generally affected more than eligibility for childless adults for two main reasons. First, most states not expanding Medicaid did not offer any income-based public coverage to nondisabled adults without children (unless they qualified as relative caretakers for children in the household or through other less common pathways) in either 2013 or 2014, so there was little or no eligibility to be affected. Second, MAGI conversion often had a larger effect on parents because 2013 parent eligibility criteria were more likely to vary by individual characteristics and to have income disregards or asset tests, distinctions eliminated by the ACA.

We model Medicaid mandatory disability-related eligibility in both 2013 and 2014 by identifying adults with functional limitations¹⁸ and comparing their income to thresholds for aged, blind, and disabled coverage. (Although functional limitation is not directly comparable to disability status as used in program eligibility determination, it is the best approximation of this concept available in this data source.) Some adults with functional limitations will gain income-based coverage under the ACA's higher income thresholds,

but income thresholds and eligibility determination procedures for disability-related coverage were not affected by ACA implementation. All states are required to continue providing Medicaid coverage to individuals receiving SSI benefits, and some states cover additional people with disabilities with higher incomes (Musumeci 2014). Therefore, eligibility for disability-related coverage is not expected to change as much under the ACA as income-based eligibility.

We categorize eligible adults in 2014 as either “pre-ACA” or “newly” eligible. Because states can no longer test for eligibility among non-MAGI-exempt groups by using the pre-ACA rules, this distinction does not refer to 2013 eligibility status but rather to reimbursement status under the ACA, for which “new” eligibility refers to adults whose income qualifies them as eligible for the new ACA match rate during the reimbursement process by the U.S. Department of Health and Human Services.¹⁹ Thus, our newly eligible category corresponds to the new mandatory Medicaid eligibility category established by the ACA. However, it is not a definitive measure of “woodwork effects,” or the extent to which previously eligible individuals enroll during eligibility expansion. Those whom we identify as pre-ACA eligible adults are largely those who would have qualified before 2014 or in the absence of the ACA, and newly eligible adults are largely those who qualify only because of changes in eligibility under the ACA. However, this distinction does not always coincide with the result of applying pre-ACA eligibility rules. In addition to the differences inherent in MAGI conversion discussed above, the 5 percent income disregard does not apply to the new eligible threshold, so conversion may have a larger impact on new versus pre-ACA eligibility than on thresholds to which the 5 percent disregard applied.

For noncitizens, both the 2013 model and the 2014 model take into account length of U.S. residency in states where this is a factor in eligibility determination. Because the ACS does not contain sufficient information to determine whether an individual is an authorized immigrant, we impute documentation status for noncitizens.

Measurement of Medicaid Participation. Medicaid participation rates are calculated as the ratio of Medicaid-eligible enrolled adults to the sum of Medicaid-eligible enrolled adults plus Medicaid-eligible uninsured adults, excluding those with both Medicaid and private coverage (including military coverage) and those with Medicaid coverage who do not have a known eligibility pathway. Participation rates excluding those with private coverage are often used to indicate how successfully Medicaid programs are reaching their primary target populations.

Under the ACA, some people will switch from private coverage to Medicaid, so this definition does not, and was not intended to, give a complete picture of Medicaid enrollment under the ACA.

Analysis. We examine levels of insurance coverage, Medicaid eligibility, and Medicaid participation nationally, by state, and when grouping states according to Medicaid expansion status as of June 2014 (the middle of the 2014 data collection period, at which point Medicaid programs in 26 states, including the District of Columbia, covered adults under the ACA). We also include analysis of estimated changes in coverage, eligibility, and participation between 2013 and 2014.²⁰ For parents, we examine changes in participation across states because all states had available coverage for parents in both 2013 and 2014. For childless adults, we present exploratory assessments of changes in only a few selected states that provided comprehensive coverage for these adults in both 2013 and 2014.

Limitations. As with our prior estimates of health insurance coverage and Medicaid eligibility and participation, and all estimates that rely on survey data and simulated program eligibility, we note that both coverage and eligibility status are likely measured with error.²¹ In particular, modeling eligibility for adults in 2013 and 2014 requires different approaches that could overstate differences between the two years. The pre-ACA adult eligibility rules are complex and the ACS, like other surveys, does not contain the detail needed to correctly capture important elements of all the major pre-ACA eligibility pathways for adults (e.g., asset tests, pregnancy status, legal disability status, income disregards related to child support, medical spending used to calculate spend-down for medically needy eligibility, duration of enrollment or income history to determine eligibility for Transitional Medical Assistance, or relative caretaker status), which likely leads to understating eligibility under pre-ACA rules. For instance, the ACS lacks information on out-of-pocket medical spending; therefore, medically needy eligibility is likely underestimated. In contrast, MAGI-based eligibility under the ACA relies on a different set of information as measured in survey

data, requiring a different set of assumptions and potential sources of bias. Because of these shifts in the rules for Medicaid eligibility determination starting in 2014, our methods for measuring eligibility in 2013 and 2014 differ, which could introduce bias into comparisons of model results between the two years.²²

Consistent with prior research, we find that, compared to children, a larger share of nonelderly adults reported as having Medicaid do not appear to be eligible for Medicaid under the pathways that we try to capture (data not shown). Overall for 2014, we find that about 22 percent of parents and childless adults covered by Medicaid do not appear to be eligible for Medicaid under the pathways that we are able to model on this survey. More research is needed to assess the underlying reasons for these patterns and the implications for analyses of Medicaid participation. Possible explanations include misreporting of coverage type, which likely has increased since the ACA introduced a new mechanism for obtaining nongroup coverage, because some people may view their subsidized marketplace coverage as “public” coverage (Pascale et al. 2013). In addition, this sort of misreporting may be a greater problem on the ACS than on other surveys given that the insurance sequence does not explicitly include a category for marketplace coverage or state specific names for Medicaid.²³

Overall, we acknowledge the uncertainty around our estimates of eligibility and participation, changes over time, and attempts to compare participation rates among newly eligible and already eligible parents. In addition, estimates for 2014 do not necessarily indicate patterns for subsequent years. Several million more people were enrolled in Medicaid in 2015 than 2014, and enrollment continued to increase modestly in 2016; additional states expanded Medicaid in 2015 and 2016; and state difficulties related to ACA implementation that affected Medicaid enrollment in 2014 have been subsequently resolved, suggesting that patterns of eligibility and participation are likely to have shifted since the first year of implementation of the ACA’s coverage provisions (CMS 2016; Kaiser Family Foundation 2016).

REFERENCES

- Bachrach, Deborah, Patricia Boozang, Avi Herring, and Dori Glanz Reyneri. 2016. "States Expanding Medicaid See Significant Budget Savings and Revenue Gains." Issue Brief. Princeton, NJ: Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097
- Baumrucker, Evelyne P, Patricia A Davis, Bernadette Fernandez, Annie L Mach, and Carol A Pettit. 2016. "The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs." Congressional Research Service. <https://www.fas.org/sgp/crs/misc/R43861.pdf>
- Blumberg, Linda, Bowen Garrett, and John Holahan. 2016. "Estimating the Counterfactual: How Many Uninsured Adults Would There Be Today Without the ACA?" *Inquiry* 53:1-13.
- Blumberg, Linda, Michael Karpman, Matthew Buettgens, and Patricia Solleveld. 2016. "Who Are the Remaining Uninsured, and What Do Their Characteristics Tell Us About How to Reach Them?" Washington, DC: Urban Institute. <http://www.urban.org/research/publication/who-are-remaining-uninsured-and-what-do-their-characteristics-tell-us-about-how-reach-them>
- Boudreaux, Michel H, Kathleen T Call, Joanna Turner, Brett Fried, and Brett O'Hara. 2015. "Measurement Error in Public Health Insurance Reporting in the American Community Survey: Evidence From Record Linkage." *Health Services Research* 50(6):1973–95.
- Brooks, Tricia, Joe Tuschner, Samantha Artiga, Jessica Stephens, and Alexandra Gates. 2015. "Modern Era Medicaid: Findings From a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP as of January 2015." Kaiser Family Foundation. Accessed March 29, 2016. <http://kff.org/medicaid/report/modern-era-medicaid-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-as-of-january-2015>
- Buettgens, Matthew. 2011. "Health Insurance Policy Simulation (HIPSIM) Methodology." Washington, DC: Urban Institute. www.urban.org/research/publication/health-insurance-policy-simulation-model-hipsim-methodology-documentation
- Buettgens, Matthew, Dean Resnick, Victoria Lynch, and Caitlin Carroll. 2013. "Documentation on the Urban Institute's American Community Survey Health Insurance Policy Simulation Model (ACS-HIPSIM)." Washington, DC: Urban Institute. <http://www.urban.org/research/publication/documentation-urban-institutes-american-community-survey-health-insurance-policy-simulation-model-acshipsim>
- Buettgens, Matthew, and Genevieve M Kenney. 2016. "What if More States Expanded Medicaid in 2017? Changes in Eligibility, Enrollment, and the Uninsured." Washington, DC: Urban Institute. <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000866-What-if-More-States-Expanded-Medicaid-in-2017-Changes-in-Eligibility-Enrollment-and-the-Uninsured.pdf>
- Center for Migration Studies. 2016. "Estimates of the Unauthorized Population for States." Accessed March 10, 2016. <http://data.cmsny.org>
- CMS (Centers for Medicare and Medicaid Services). 2016. "Medicaid & CHIP: June 2016 Monthly Applications, Eligibility Determinations and Enrollment Report." Washington, DC: Department of Health and Human Services. <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/june-2016-enrollment-report.pdf>
- . 2014a. "State Medicaid and CHIP Income Eligibility Standards." <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-eligibility-levels-table.pdf>
- . 2014b. "Targeted Enrollment Strategies." <http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Targeted-Enrollment-Strategies/targeted-enrollment-strategies.html>
- . 2013. "MAGI: Medicaid and CHIP's New Eligibility Standards." <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/modified-adjusted-gross-income-and-medicaid-chip.pdf>
- Dorn, Stan, and Matthew Buettgens. 2016. "The Cost to States of not Expanding Medicaid." Washington, DC: Urban Institute. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf430767
- Dorn, Stan, Norton Francis, Laura Snyder, and Robin Rudowitz. 2015. "The Effects of Medicaid Expansion on State Budgets: An Early Look in Select States." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states>

Frean, Molly, Jonathan Gruber, and Benjamin D Sommers. 2016. "Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act." National Bureau of Economic Research Working Paper No. 22213. <http://www.nber.org/papers/w22213>

Golberstein, E, G Gonzales, and BD Sommers. 2015. "California's Early ACA Expansion Increased Coverage and Reduced Out-Of-Pocket Spending for Medicaid Population." *Health Affairs* 34(10):1688–94.

Heberlein, Martha, Tricia Brooks, Joan Alker, Samantha Artiga, and Jessica Stephens. 2013. "Getting Into Gear for 2014: Findings From a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012–2013." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf>

Heberlein, Martha, Tricia Brooks, Samantha Artiga, and Jessica Stephens. 2013. "Getting Into Gear for 2014: Shifting New Medicaid Eligibility and Enrollment Policies Into Drive." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kff.org/medicaid/report/getting-into-gear-for-2014-shifting-new-medicaid-eligibility-and-enrollment-policies-into-drive>

Heberlein, Martha, Michael Huntress, Genevieve Kenney, Joan Alker, Victoria Lynch, and Tara Mancini. 2012. "Medicaid Coverage for Parents Under the Affordable Care Act." Washington, DC: Georgetown University Center for Children and Families. <http://ccf.georgetown.edu/wp-content/uploads/2012/06/Medicaid-Coverage-for-Parents1.pdf>

Kaestner, Robert, Bowen Garrett, Anuj Gangopadhyaya, and Caitlyn Fleming. 2015. "Effects of ACA Medicaid Expansions on Health Insurance Coverage and Labor Supply." National Bureau of Economic Research Working Paper No. 21836.

Kaiser Family Foundation. 2016. "Status of State Action on the Medicaid Expansion." <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act>

Kenney, Genevieve, Jennifer Haley, Nathaniel Anderson, and Victoria Lynch. 2015. "Children Eligible for Medicaid or CHIP: Who Remains Uninsured, and Why?" *Academic Pediatrics* 15(3 Suppl):S36–S43.

Kenney, Genevieve, Jennifer Haley, Clare Pan, Victoria Lynch, and Matthew Buettgens. 2016. "Children's Coverage Climb Continues: Uninsurance and Medicaid/CHIP Eligibility

and Participation Under the ACA." Princeton, NJ: Robert Wood Johnson Foundation.

Kenney, Genevieve, Michael Huntress, Matthew Buettgens, Victoria Lynch, and Dean Resnick. 2013. "State and Local Coverage Changes Under Full Implementation of the Affordable Care Act." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kff.org/report-section/state-and-local-coverage-changes-under-full-implementation-of-the-affordable-care-act-report>

Kenney, Genevieve, Victoria Lynch, Jennifer Haley, and Michael Huntress. 2012. "Variation in Medicaid Eligibility and Participation Among Adults: Implications for the Affordable Care Act." *Inquiry* 49(3):231–53.

Kenney, Genevieve, Victoria Lynch, Michael Huntress, Jennifer Haley, and Nathaniel Anderson. 2012. "Medicaid/CHIP Participation Among Children and Parents." Princeton, NJ: Robert Wood Johnson Foundation. www.rwjf.org/en/research-publications/find-rwjf-research/2012/12/medicaid-chip-participation-among-children-and-parents.html

Kenney, Genevieve, Stephen Zuckerman, Lisa Dubay, Michael Huntress, Victoria Lynch, Jennifer Haley, and Nathaniel Anderson. 2012. "Opting In to the Medicaid Expansion Under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?" Princeton, NJ: Robert Wood Johnson Foundation. <http://www.rwjf.org/coverage/product.jsp?id=74697>

Lynch, Victoria, Michael Boudreaux, and Michael Davern. 2010. "Applying and Evaluating Logical Coverage Edits to Health Insurance Coverage in the American Community Survey." Suitland, MD: U.S. Census Bureau, Health Insurance Technical Advisory Group.

Lynch, Victoria, Jennifer Haley, and Genevieve M Kenney. 2014. "The Urban Institute Health Policy Center's Medicaid/CHIP Eligibility Simulation Model." Washington, DC: Urban Institute. Accessed April 25, 2016. <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/413069-The-Urban-Institute-Health-Policy-Center-s-Medicaid-CHIP-Eligibility-Simulation-Model.PDF>

Lynch, Victoria, and Genevieve Kenney. 2013. "Improving the American Community Survey for Studying Health Insurance Reform." In *Proceedings of the 10th Conference on Health Survey Research Methods*, edited by Stephen J Blumberg and Timothy P Johnson, 87–94. Hyattsville, MD: U.S. Department of Health and Human Services.

Lynch, Victoria, Genevieve M Kenney, Jennifer Haley, and Dean M Resnick. 2011. "Improving the Validity of the

- Medicaid/CHIP Estimates on the American Community Survey: The Role of Logical Coverage Edits.” Submitted to the U.S. Census Bureau. www.census.gov/hhes/www/hitthins/publications/Improving%20the%20Validity%20of%20the%20Medicaid-CHIP%20Estimates%20on%20the%20ACS.pdf
- Lynch, Victoria, and Dean Resnick. Forthcoming. “Measurement Error in Edits to Medicaid, CHIP and Other Means-Tested Health Coverage in the American Community Survey (ACS).”
- MACPAC (Medicaid and CHIP Payment and Access Commission). 2016. “State and Federal Spending Under the ACA.” <https://www.macpac.gov/subtopic/state-and-federal-spending-under-the-aca>
- . 2012. “Medicaid and CHIP Program Statistics: March 2012 MACStats.” <https://www.macpac.gov/wp-content/uploads/2015/03/March-2012-MACStats.pdf>
- Martinez, Michael E, Robin A Cohen, and Emily P Zammiti. 2016. “Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–September 2015.” Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics. www.cdc.gov/nchs/data/nhis/earlyrelease/insur201602.pdf
- McMorrow, Stacey, Genevieve M. Kenney, Sharon K. Long, and Dana E. Goin. “Medicaid Expansions from 1997 to 2009 Increased Coverage and Improved Access and Mental Health Outcomes for Low-Income Parents.” *Health Services Research* 51(4):1347-1367.
- Musumeci, MaryBeth. 2014. “The Affordable Care Act’s Impact on Medicaid Eligibility, Enrollment, and Benefits for People With Disabilities.” Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kff.org/health-reform/issue-brief/the-affordable-care-acts-impact-on-medicaid-eligibility-enrollment-and-benefits-for-people-with-disabilities>
- Pascale, Joanne, Jonathan Rodean, Jennifer Leeman, Carol Cosenza, and Alisu Schoua-Glusberg. 2013. “Preparing to Measure Health Coverage in Federal Surveys Post-Reform: Lessons From Massachusetts.” *Inquiry: Journal of Health Care Organization, Provision, and Financing* 50(2):106–23.
- Passel, Jeffrey S, and D’Vera Cohn. 2014. “Unauthorized Immigrant Totals Rise in 7 States, Fall in 14: Decline in Those From Mexico Fuels Most State Decreases.” Washington, DC: Pew Research Center. www.pewhispanic.org/2014/11/18/chapter-1-state-unauthorized-immigrant-populations
- Rosebaum, Sara, and Timothy M Westmoreland. 2012. “The Supreme Court’s Surprising Decision on the Medicaid Expansion: How Will the Federal Government and States Proceed?” *Health Affairs* 31(8):1663–72.
- Ruggles, Steven, J Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B Schroeder, and Matthew Sobek. 2010. Integrated Public Use Microdata Series: Version 5.0 [machine-readable database]. Minneapolis: University of Minnesota.
- Shartzter, Adele, Sharon K Long, Michael Karpman, Genevieve M Kenney, and Stephen Zuckerman. 2015. “QuickTake: Insurance Coverage Gains Cross Economic, Social, and Geographic Boundaries.” Washington, DC: Urban Institute. <http://hrms.urban.org/quicktakes/Insurance-Coverage-Gains-Cross-Economic-Social-and-Geographic-Boundaries.html>
- Skopec, Laura, John Holahan, and Patricia Solleveld. Forthcoming. “Health Insurance Coverage in 2014: Significant Progress but Gaps Remain.”
- Sommers, Benjamin D, Emily Arntson, Genevieve M Kenney, and Arnold M Epstein. 2013. “Lessons From Early Medicaid Expansions Under Health Reform: Interviews With Medicaid Officials.” *Medicare and Medicaid Research Review* 3(4):E1–E19.
- Sommers, BD, KP Chur, GM Kenney, SK Long, and S McMorrow. 2015. “California’s Early Coverage Expansion Under the Affordable Care Act: A County-Level Analysis.” *Health Services Research*. doi: 10.1111/1475-6773.12397
- U.S. Census Bureau. 2014. “American Community Survey: Response Rates.” Accessed March 24, 2016. www.census.gov/acs/www/methodology/sample-size-and-data-quality/response-rates
- Wherry, Laura R, and Sarah Miller. 2016. “Early Coverage, Access, Utilization, and Health Effects Associated With the Affordable Care Act Medicaid Expansions.” *Annals of Internal Medicine*. doi: 10.7326/M15-2234

ENDNOTES

1. Some adults who are not parents can qualify through pathways related to caretaking of children, such as relative caretaker pathways. See Methodological Appendix.
2. The implementation of the ACA's coverage provisions in 2014 represented a decline in parents' eligibility for several expansion states (Heberlein, Brooks, Artiga, and Stephens, 2013); some of these parents may qualify for subsidized marketplace coverage in 2014.
3. Medicaid participation rates are calculated as the ratio of Medicaid-eligible enrolled adults to the sum of Medicaid-eligible enrolled adults plus Medicaid-eligible uninsured adults, excluding those with both Medicaid/CHIP and private coverage (including military coverage) and those with Medicaid/CHIP coverage who do not have a known eligibility pathway.
4. For simulating eligibility, we define parents according to eligibility rules and include relative caretakers as "parents" when appropriate. As a result, nonparent adults may be classified as eligible under relative caretaker provisions. However, these adults are not included with parents in the tables in this brief.
5. Pre-ACA disregard policies varied considerably across states. The effect of income disregards in some states was substantial. For instance, in Florida, the average threshold for nonworking parents was 19 percent of FPL, but for working parents (incorporating work disregards) it was 56 percent of FPL. Meanwhile, the effect of income disregards was lower in other states. For example, in South Dakota, the thresholds for working and nonworking parents were the same, at 50 percent of FPL (Heberlein, Brooks, Alker, et al. 2013).
6. Six states (California, Connecticut, District of Columbia, Minnesota, New Jersey, and Washington) took advantage of the ACA provision to expand Medicaid before 2014; estimates for 2013 include the effects of Medicaid expansion in these early expander states when the coverage they provided was comprehensive and statewide (Golberstein, Gonzales, and Sommers 2015; Sommers et al. 2013, 2015). We classify Connecticut, the District of Columbia, and Minnesota as having comprehensive, statewide early ACA expansion programs in 2013. To the extent that some adults in the remaining early expansion states could have qualified for ACA coverage in 2013 but could not be identified as eligible due to methodological limitations, differences between 2013 and 2014 eligibility could be overstated in those states. In addition, programs that do not provide comprehensive Medicaid or Medicaid-equivalent benefits are excluded. See Methodological Appendix.
7. For background on the newly eligible match rate, see MACPAC (2016).
8. Our imputations of documentation status for 2013 and 2014 differ from our prior method. The 2013 and 2014 approach incorporates estimated patterns of documentation status within families as reported on the Survey of Income and Program Participation and includes additional state-level information that is calibrated to replicate estimates of the undocumented population in 15 states and nationwide produced by the Pew Hispanic Center (see chapter 1 of Passel and Cohn [2014]), the age distribution of undocumented immigrants estimated by the U.S. Department of Homeland Security, and the share of undocumented immigrants lacking insurance estimated by the Center for Migration Studies (2016).
9. See Methodological Appendix for more detail.
10. In states that have not expanded Medicaid, people under 100 percent of FPL are generally not eligible for marketplace tax credits, so nearly all new health insurance coverage would be due to new Medicaid enrollment. (Legally present immigrants who are ineligible for Medicaid because they have been resident less than five years may be eligible for tax credits even if their incomes are below 100 percent of the FPL.)
11. We conducted exploratory analysis of changes in participation for childless adults in selected states with comprehensive programs in both 2013 and 2014. We found increases in participation of 9.5, 8.3, and 10.9 percentage points, respectively, for Delaware, New York, and Vermont, indicating that childless adults experienced similar increases as parents under the ACA in states that had comprehensive eligibility for childless adults before the ACA. Other states offered coverage for childless adults but presented methodological challenges in examining changes in participation rates over time. For example, Arizona and Hawaii offered Section 1115 programs to nonparents in 2013 and adopted the Medicaid expansion; but because their programs were closed to new enrollees in 2013, participation among eligible adults is more difficult to assess.
12. Both the administrative data reported by states to CMS and the ACS data used here indicate increases in Medicaid/CHIP enrollment among adults and children between mid-2013 and mid-2014. For the most part, states reporting gains in enrollment also saw these gains reflected in the ACS data, although changes were generally smaller in the survey data than in the administrative data, and the direction and magnitude of changes were different for some states (CMS 2016).
13. Results for 2013 are not directly comparable to those for 2009 as estimated in Kenney, Lynch, Haley, and Huntress (2012). The 2013 model applies updated information on state-specific income disregards and other eligibility rules for the pre-ACA period and also incorporates a new approach to imputation of documentation status. If the updated eligibility rules and disregards were applied to the 2009 model, the national participation rate and rates for some states would be slightly higher than estimated in Kenney, Lynch, Haley, and Huntress (2012). In addition, some states have expanded or reduced eligibility since 2009. If states have expanded eligibility, modeled participation rates would tend to be lower after the expansion, but if states have restricted eligibility, modeled participation rates are expected to be higher. Only three states (District of Columbia, Connecticut, and Minnesota) experienced a notable decrease in overall adult Medicaid participation between 2009 and 2013; these three are early ACA expansion states that began early eligibility in 2010 or 2011.
14. A recent analysis of the remaining uninsured in 2015 relying on a different data source (Current Population Survey: Annual Social and Economic Supplement) found broadly similar results, with an estimated 31.5 million uninsured adults in spring 2015, of whom 8.2 million (20.6 percent) are estimated to be Medicaid eligible (Blumberg et al. 2016). The time period of this analysis reflects a much more mature ACA, when more states were participating in the Medicaid expansion and Medicaid enrollment was higher than in 2014.
15. Nationwide, approximately 370,000 adults in 2013 and 339,000 adults in 2014 were found to have Indian Health Service (IHS) coverage but did not report any other insurance coverage. For most expansion states in 2014, the participation rates for parents do not change in a meaningful way when IHS is considered a source of health insurance coverage. However, in North Dakota the participation rate increases by more than 5 percentage points when IHS is reclassified as insurance coverage.
16. See endnote 5.
17. Fifteen states were early MAGI conversion states, having adopted MAGI methodology for eligibility determination by October 1, 2013, for the initial months of open enrollment for marketplace coverage, which could have made a small difference in Medicaid eligibility simulation results. However, coverage would not have been effective for new eligibles until January 1, 2014, and the new methodology was not in effect in mid-2013, so this change in eligibility policy was not modeled for these states for 2013 (CMS 2014b).
18. Functional limitation status is identified by responses to questions on serious difficulty walking or climbing stairs; difficulty dressing or bathing; serious difficulty hearing or serious difficulty seeing when not wearing glasses; and serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition. Adults with affirmative responses to one or more of these questions are classified as having a functional limitation.
19. See endnote 7.
20. See endnote 6.
21. In addition, there is more error inherent in estimates reported for smaller states. In particular, 15 states (Alaska, Delaware, District of Columbia, Hawaii, Idaho, Kansas, Maine, Montana, Nebraska, New Hampshire, North Dakota, Rhode Island, Utah, Vermont, and Wyoming) had sample sizes of fewer than 1,000 cases for estimates of participation in 2014. Estimates with smaller samples are more volatile and are likely to be more sensitive to changes in methodology.
22. As an example of one methodological difference between the 2013 and 2014 models, in an attempt to address the limitations associated with not being able to

capture all of the different pre-ACA eligibility pathways and all of the details of the pathways we simulate in 2013, we impute eligibility to some sample people with reported Medicaid who met the categorical requirements for eligibility but whose reported incomes were not below eligibility thresholds. For example, we edit to eligible adults who meet the immigration requirements with functional limitations and reported Medicaid with incomes above the eligibility thresholds because our simulation does not take into account all the factors used to determine disability-based eligibility (e.g., income disregards in certain states and legal definitions of disability). However, for 2014, because of the shift to MAGI-based eligibility, the elimination of the more complex eligibility pathways that are not MAGI exempt (Baumrucker et al. 2016), and less assumed bias in identifying those enrolled through complex pathways, we do not edit any sample people to eligibility. Medicaid reporters with incomes above the applicable MAGI thresholds are assumed ineligible unless they qualify for a non-MAGI pathway according to our model.

23. Our coverage edits reclassify some sample people reporting nongroup coverage who are eligible for Medicaid as having Medicaid coverage. We also conducted exploratory analysis in Arkansas and Iowa, where many new Medicaid enrollees have obtained coverage through marketplace plans. We found little difference in our estimates of Medicaid participation, Medicaid coverage, and changes between 2013 and 2014 when we reclassified eligible adults reporting nongroup coverage as having Medicaid in 2014.

Copyright© September 2016. The Urban Institute. Permission is granted for reproduction of this file, with attribution to the Urban Institute.

About the Authors and Acknowledgements

Genevieve M. Kenney is a senior fellow and codirector, Jennifer Haley is a research associate, Clare Pan is a research associate, Victoria Lynch is a research associate, and Matthew Buettgens is a senior research associate in the Health Policy Center of the Urban Institute. This study was funded by the Robert Wood Johnson Foundation. The authors are grateful to Linda Blumberg, April Grady, John Holahan, and Cindy Mann for helpful comments and suggestions.

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are striving to build a national Culture of Health that will enable all to live longer, healthier lives now and for generations to come. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at [www.rwjf.org/twitter](https://twitter.com/rwjf) or on Facebook at [www.rwjf.org/Facebook](https://www.facebook.com/rwjf).

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic and governance problems facing the nation. For more information, visit www.urban.org. Follow the Urban Institute on Twitter [www.urban.org/twitter](https://twitter.com/urbanorg) or Facebook [www.urban.org/facebook](https://www.facebook.com/urbanorg). More information specific to the Urban Institute's Health Policy Center, its staff, and its recent research can be found at www.healthpolicycenter.org.