

RESEARCH REPORT

Medicaid-Eligible Adults Who Lack Private Coverage and Are Not Enrolled

Are They Uninsured?

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Medicaid-Eligible Adults Who Lack Private Coverage and Are Not Enrolled

Recent reports estimate that about 17 to 20 percent of uninsured people (about 5 to 6 million people) were eligible for Medicaid or CHIP and not enrolled in 2019 and 2020 (Buettgens and Banthin 2020; CBO 2020). People who are eligible for Medicaid but not enrolled in the program or in any other source of coverage have long been considered by many to be uninsured. Some have argued, however, that policymakers should consider this group of people insured or less than completely uninsured because they can enroll in Medicaid if they need medical care (Besharov 2000; CBO 2020; Cutler and Gruber 1996; Gruber and Levy 2009).¹ The extent to which eligible but uninsured adults behave as if they possess “contingent” or “provisional” coverage that can be accessed if they need health care has important policy implications both for how we interpret counts of the uninsured and for understanding the importance of policies to promote the enrollment and retention of eligible adults in Medicaid.

Research from two decades ago did not support the notion of eligible but uninsured adults behaving as if they were insured, finding that eligible but uninsured adults used fewer health services, were more likely to have unmet health care needs, and had higher out-of-pocket health care spending than Medicaid enrollees with the same health and demographic characteristics (Davidoff, Garrett, and Yemane 2000). There have been many changes since that research was conducted, however, including enactment of the Affordable Care Act (ACA).

Under the ACA, many states expanded Medicaid to include adults at higher income thresholds and in categorical groups, including childless adults, that previously had limited or no eligibility. In addition, the ACA introduced enrollment and procedural simplifications that might have altered the extent of provisional coverage experienced by eligible but uninsured adults. Under the ACA, enrollment procedures that once required multiple sources of verification were streamlined and simplified for many Medicaid-eligible adults. The ACA also expanded the use of Medicaid presumptive eligibility by hospitals to all states. With presumptive eligibility, hospitals (and, in some states, certain other health care entities such as clinics) may temporarily enroll patients in Medicaid to allow immediate access to care and guarantee payment to providers. Combining Medicaid’s open enrollment with simplified application processes and expanded presumptive eligibility may have increased the extent to which unenrolled but eligible persons are effectively insured.

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. Through the US Health Reform—Monitoring and Impact project, which began in May 2011, Urban researchers are using microsimulation modeling to project the cost and coverage implications of proposed health reforms, documenting the implementation of national and state health reforms, and providing technical assistance to states. More information and publications can be found at www.rwjf.org and www.urban.org.

The extent to which Medicaid-eligible but uninsured adults actually benefit from Medicaid's provisional coverage may depend, in part, on whether they are aware of their eligibility. Yet even those who suspect they may be eligible may not know how to complete enrollment procedures. Lack of access to technology could be a further barrier to understanding eligibility and enrollment procedures. Also, while presumptive eligibility has been expanded, people eligible for presumptive eligibility are not always presumptively enrolled, especially if they seek care from providers other than hospitals. For example, many office-based providers do not accept uninsured patients unless they pay the full cost up front (Saloner et al. 2018). In addition, eligible but uninsured adults may have trouble filling prescriptions because pharmacies are not included among the entities that may presumptively enroll people in Medicaid.

To provide updated insights into the role of Medicaid's provisional coverage, we used data from the Medical Expenditure Panel Survey Household Component (MEPS-HC)² to examine the socioeconomic characteristics, health status, access to care, utilization of care, and out-of-pocket spending of Medicaid-eligible but uninsured adults. We compared the Medicaid-eligible uninsured with other low-income adults who were (1) similar by virtue of also being Medicaid eligible, but who were covered by insurance or (2) similar by virtue of also being uninsured, but who were ineligible for Medicaid.

To the extent Medicaid eligibles who were uninsured had access to care, utilization, and out-of-pocket spending burdens similar to those who were insured, our results would tend to support the view that Medicaid provides substantial coverage regardless of actual enrollment. In contrast, if the Medicaid-eligible uninsured reported limitations on access to care, low utilization of services, and high out-of-pocket burdens that were more like other low-income uninsured adults who were not Medicaid eligible, then our results would suggest that provisional coverage is far from complete. This similarity between Medicaid-eligible uninsured and other uninsured adults may be the result of lack of awareness

of eligibility or other barriers to taking up Medicaid. In other words, the results would support the view that Medicaid-eligible but unenrolled adults behave as if they are uninsured and may be counted as such. Such results would also highlight the importance of Medicaid policies to improve outreach, simplify enrollment, and increase retention.

Empirical Strategy

To address the question of how policymakers could most accurately count the more than 5 million people who are eligible for Medicaid but not enrolled in coverage—and related questions regarding the importance of policies to increase Medicaid enrollment and retention—we compared our focal group of uninsured adults who were simulated to be eligible for Medicaid with four comparison groups. We compared our focal group with each comparison group first on a range of socioeconomic characteristics and health status measures and then with respect to outcomes regarding access to care, utilization of care, and out-of-pocket spending. Because the differences between insurance groups can in part stem from the selection process that led to the coverage we observed, rather than as consequences of that coverage, we examined both adjusted and unadjusted differences in outcomes across groups.

The first comparison group was adult Medicaid enrollees (persons simulated to be eligible for and enrolled in Medicaid). The second group was Medicaid-eligible adults enrolled in private insurance. Examining these comparison groups can tell us how outcomes differed between our focal group and similarly eligible adults who had public and private coverage.

We also compared our focal group with other low-income uninsured adults who were *ineligible* for Medicaid. This third comparison group consisted of uninsured adults who were living in states that had not expanded Medicaid and who were not eligible for either Medicaid or, because they had incomes below the federal poverty level (FPL), subsidized Marketplace coverage. Unlike the eligible uninsured, these “coverage-gap uninsured” people lacked any access to public or publicly funded coverage, whether provisional or not.

The fourth comparison group consisted of Medicaid-ineligible adults who were uninsured but had slightly higher incomes, in the income range for subsidized Marketplace coverage. Much like the adults in our focal group who did not enroll despite being eligible for public coverage, this fourth group of “Marketplace-eligible uninsured” adults remained uninsured despite likely having been eligible for publicly subsidized Marketplace coverage (note that Marketplace eligibility also required a lack of access to affordable employer-sponsored coverage—a test we did not apply). Because Marketplace

coverage must be acquired during an open enrollment period (or a special enrollment period for those who qualify), this group, like the coverage-gap uninsured people described above, lacked access to provisional coverage of the sort Medicaid in principle provides.

To the extent that Medicaid-eligible uninsured adults reported characteristics and outcomes more similar to those of the ineligible uninsured groups than to those of the eligible insured groups, such results would be inconsistent with the notion of contingent coverage that can be accessed if needed. Instead, such results would indicate that eligible uninsured adults may not be aware of their eligibility or may face other barriers to enrollment. Our research may therefore help to clarify how policymakers could most accurately interpret official uninsurance counts and offer insights into the importance of policies, including outreach and administrative simplification, aimed at enrolling eligible adults into actual, rather than just provisional, coverage.

Methods

The MEPS-HC, sponsored by the Agency for Healthcare Research and Quality, is a nationally representative household survey of the civilian noninstitutionalized population that collects information from individuals and their families on health care use, health care expenditures, access to care, insurance coverage, and other demographic, socioeconomic, and health-related characteristics. Each calendar year of information is derived from three interviews with an average reference period of five months. Questions about access to care are asked in the second interview of the calendar year.

The MEPS-HC has detailed information that facilitates simulating the Medicaid eligibility of individuals, including amounts and sources of income, family relationships, and state of residence. The PUBSIM model uses this information, in combination with detailed state- and year-specific income threshold and other eligibility rules, to simulate eligibility for Medicaid. Eligibility is based on end-of-the-year family relationships and family income defined using annual modified adjusted gross income. Details of the PUBSIM model have been published elsewhere (Decker, Abdus, and Lipton 2021; Jacobs, Hill, and Abdus 2017; Abdus, Mistry, and Selden 2015).

We used data from the 2014–18 MEPS-HC. We restricted our analysis to citizen adults ages 19 to 64. We excluded adults who were enrolled in Medicare or any other public insurance (other than Medicaid) at any time during the calendar year. Our primary focus was on Medicaid-eligible adults who were uninsured throughout the (calendar) year (“Medicaid-eligible uninsured,” $n = 1,856$).

The two insured comparison groups were Medicaid-eligible adults enrolled in Medicaid any time during the year (“Medicaid enrollees,” $n = 9,794$) and Medicaid-eligible adults who held private insurance any time during the year and never held Medicaid coverage (“Medicaid-eligible privately insured,” $n = 3,398$). The two uninsured comparison groups were uninsured adults in states that had not expanded Medicaid during the MEPS survey year who were ineligible for Medicaid and had family incomes below FPL, making them ineligible for subsidized Marketplace coverage (“coverage-gap uninsured,” $n = 1,829$) and Medicaid-ineligible adults with incomes between 100 percent FPL and 200 percent FPL who were uninsured despite being eligible for subsidized Marketplace coverage (“Marketplace-eligible uninsured,” $n = 2,171$).

We examined a range of measures in the following four categories: (1) socioeconomic characteristics (age, sex, race/ethnicity, and poverty level based on census family and income definitions) and health measures (self-reporting fair or poor physical health or mental health and having two or more chronic conditions); (2) access measures (whether the adult had a usual source of care other than the emergency room and whether the adult could not afford needed medical care, delayed needed medical care because of the cost, and could not afford prescription medicines); (3) medical care utilization during the (calendar) year (whether the adult had any office-based and outpatient department doctor visits, any prescription drug, any emergency room visits, and any hospital discharges); and (4) health care spending (individual out-of-pocket health care expenditures during the year and whether family out-of-pocket health care expenditures exceeded 10 percent of family income during the year). We provide additional details regarding variable construction and sample sizes, as well as more complete socioeconomic characteristics of our five samples, in appendix A.

Our analyses from unadjusted weighted means and from adjusted multivariate regressions yielded broadly similar results. We present unadjusted weighted means for simplicity; adjusted differences can be found in appendix A. Our adjusted differences controlled for survey year, sex, age groups, race/ethnicity, poverty level, education, employment status, marital status, census region, whether the adult lives in a metropolitan statistical area, number of children, fair or poor self-reported health, fair or poor self-reported mental health, and having multiple chronic conditions.

Statistical significance of the differences in predicted outcomes between adult groups was assessed using two-tailed t -tests. All analyses incorporated MEPS sample weights, and standard errors accounted for the complex survey design of the MEPS. The analyses were conducted using Stata/MP, version 15.0. All differences discussed in the results section were significant at the 5 percent level.

Results

Socioeconomic Characteristics and Health Status

Table 1 compares the socioeconomic characteristics and health status of Medicaid-eligible uninsured adults with those of the four comparison groups. Our focal group was substantially less likely to be female (41.5 percent) than either of the two insured comparison groups (61.3 percent of Medicaid enrollees and 50.8 percent of Medicaid-eligible adults with private insurance). The percentage female among uninsured Medicaid-eligible adults was more similar to that of the coverage-gap uninsured (43.8 percent) and the Marketplace-eligible uninsured (42.2 percent).

TABLE 1
Socioeconomic Characteristics and Health Status of Medicaid-Eligible Uninsured and Selected Insured and Uninsured Comparison Groups, 2014–18
Percent

| | Medicaid-eligible uninsured | Insured Comparison Groups | | Uninsured Comparison Groups | |
|-----------------------------|-----------------------------|---------------------------|-------------------------------------|-----------------------------|--------------------------------|
| | | Medicaid enrollees | Medicaid-eligible privately insured | Coverage-gap uninsured | Marketplace-eligible uninsured |
| Sex | | | | | |
| Female | 41.5 | 61.3** | 50.8** | 43.8 | 42.2 |
| Race/ethnicity | | | | | |
| White (non-Hispanic) | 48.1 | 50.1 | 62.9** | 44.8 | 50.5 |
| Black (non-Hispanic) | 18.4 | 20.9* | 10.3** | 29.1** | 19.9 |
| Hispanic | 23.7 | 19.7* | 14.3** | 18.6 | 24.0 |
| Other (non-Hispanic) | 9.8 | 9.3 | 12.6 | 7.5 | 5.6** |
| Age group | | | | | |
| 19–34 | 57.5 | 51.1** | 71.7** | 46.2** | 46.1** |
| 35–49 | 23.7 | 26.4 | 13.4** | 26.5 | 27.3 |
| 50–64 | 18.9 | 22.5* | 14.9* | 27.3** | 26.6** |
| Poverty level | | | | | |
| 50% FPL and below | 25.6 | 26.1 | 12.7** | 30.4* | 0.7** |
| 51–100% FPL | 21.0 | 28.6** | 13.9** | 39.9** | 2.3** |
| 101–150% FPL | 20.8 | 20.1 | 17.4 | 12.0** | 27.2** |
| Over 150% FPL | 32.6 | 25.3** | 55.9** | 17.7** | 69.8** |
| Health status | | | | | |
| Fair/poor health | 12.4 | 24.8** | 8.3** | 21.4** | 12.3 |
| Fair/poor mental health | 9.5 | 19.3** | 7.8 | 16.9** | 7.6 |
| Multiple chronic conditions | 12.0 | 26.3** | 10.3 | 19.2** | 14.7 |

Source: Authors' calculations from the Medical Expenditure Panel Survey Household Component (MEPS-HC), 2014–18.

Notes: $N = 19,048$. Estimates are population weighted. For all analysis groups, the samples are restricted to citizen adults ages 19–64. The samples of Medicaid enrollees and Medicaid-eligible privately insured also exclude those with Medicare or other public insurance. Chronic conditions include diabetes, asthma, high blood pressure, stroke, emphysema, arthritis, cancer, chronic

bronchitis, and heart diseases (coronary heart disease, angina, myocardial infarction, or any other heart condition or heart disease).

FPL = federal poverty level.

*Statistically significantly different from the Medicaid-eligible uninsured group at the 5 percent level. **Statistically significantly different from the Medicaid-eligible uninsured group at the 1 percent level.

Our focal group of Medicaid-eligible uninsured adults had a substantially different racial and ethnic composition, even in our sample of US citizens, than the general US resident population. Our focal group was 18.4 percent Black (non-Hispanic) and 23.7 percent Hispanic, versus 12.5 percent and 17.8 percent, respectively, among adults ages 19 to 64 in the broader population (results not shown, using the full MEPS sample).

The racial and ethnic composition of the Medicaid-eligible uninsured was similar to that of Medicaid enrollees and the Marketplace-eligible uninsured. The coverage-gap uninsured had a higher percentage of Black (non-Hispanic) adults than our focal group, whereas Medicaid-eligible privately insured adults had a higher percentage of white (non-Hispanic) adults than our focal group.

Among the Medicaid-eligible uninsured, 57.5 percent were ages 19 to 34. This focal group was younger on average than the two uninsured comparison groups (each had just over 46 percent in the ages 19 to 34 category) and modestly younger than Medicaid enrollees (with 51.1 percent ages 19 to 34). In contrast, our focal group was older than the Medicaid-eligible privately insured (with 71.7 percent ages 19 to 34).

The poverty distribution among the Medicaid-eligible uninsured was broadly similar to that among Medicaid enrollees. In contrast, Medicaid-eligible adults with private insurance were only half as likely as our focal group to have had incomes below 50 percent of FPL (and more likely to have had income above 150 percent of FPL). Uninsured adults in the coverage gap had lower incomes than uninsured Medicaid-eligible adults, whereas the reverse was true for the low-income eligible uninsured receiving Marketplace subsidies. These poverty distribution differences among the three uninsured groups were largely driven by the income criteria on which the groups were based (however, the census measure of poverty used to define the table 1 poverty distributions differed from the annual modified adjusted gross income measure used to define the three groups).

The last three rows of table 1 present our three health status measures. Medicaid enrollees were more than twice as likely as the Medicaid-eligible uninsured to report fair or poor health (24.8 percent versus 12.4 percent), fair or poor mental health (19.3 percent versus 9.5 percent), and multiple chronic conditions (26.3 percent versus 12.0 percent). In contrast, the Medicaid eligible who are privately insured tend to be somewhat healthier (with a significantly lower percentage reporting fair or poor

health), perhaps reflecting their younger age distribution. The Marketplace-eligible uninsured have similar health status compared with the Medicaid-eligible uninsured, whereas uninsured adults in the coverage gap have health status similar to that of Medicaid enrollees.

The socioeconomic and health status differences we observed in table 1 across the five groups we studied suggest a considerable degree of sorting, especially within the Medicaid-eligible population. Indeed, the large health differences we observed between the Medicaid-eligible uninsured and Medicaid enrollees may in part reflect the very provisional coverage we are seeking to study (to the extent that individuals with worse health were more likely to end up using Medicaid during the year). It is important to interpret the estimated differences in outcomes that follow in light of the differences in table 1. In addition, these differences motivated us to examine both unadjusted and adjusted estimates of outcomes.

Access to Care

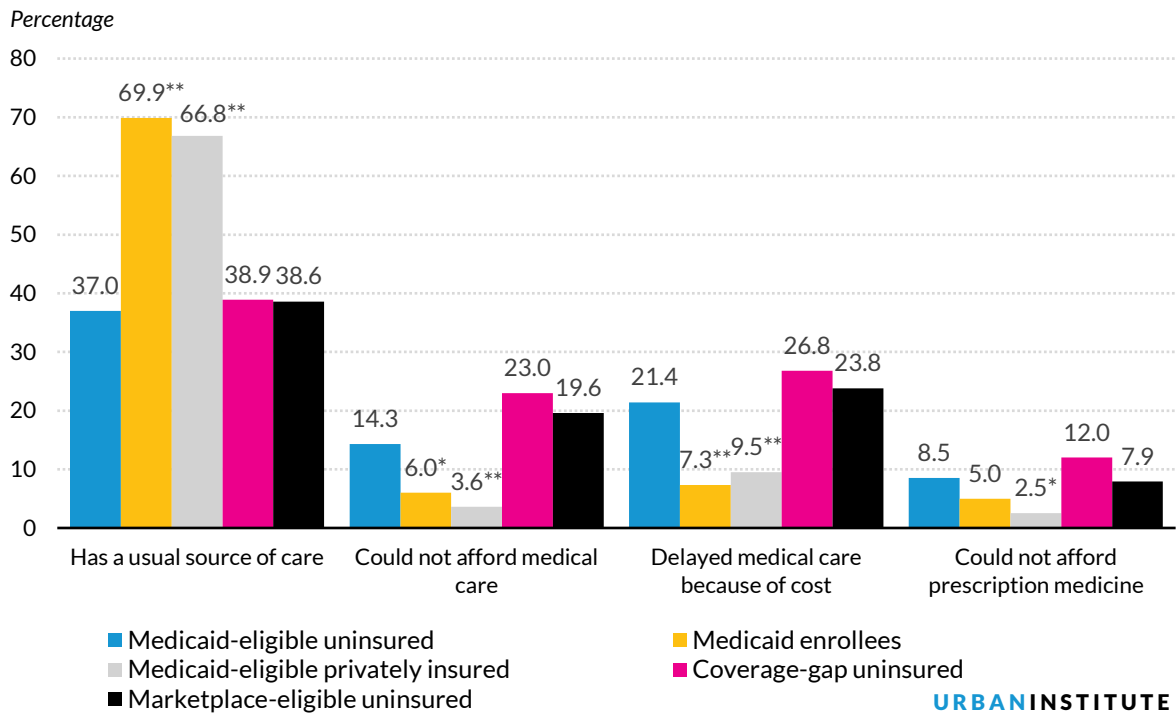
Medicaid-eligible uninsured adults were much less likely to have a usual source of care (37.0 percent) than adults in either insured comparison group (69.9 percent among Medicaid enrollees and 66.8 percent among Medicaid eligibles with private insurance) (figure 1). In contrast to these two insured groups, the share of Medicaid-eligible uninsured adults with a usual source of care was more like that of the two uninsured comparison groups (38.9 percent among the coverage-gap uninsured and 38.6 percent among low-income uninsured adults who were eligible for subsidized Marketplace coverage).

Our results for having a usual source of care presented a clear distinction between the Medicaid-eligible uninsured and the two comparison groups of adults with insurance coverage. Our results regarding barriers to care reveal a similar pattern. Among the Medicaid-eligible uninsured, 14.3 percent of adults were unable to afford needed medical care, whereas only 6.0 percent of Medicaid enrollees and 3.6 percent of the Medicaid-eligible privately insured faced such barriers. The Medicaid-eligible uninsured were more likely than the insured groups to report they delayed medical care because of cost (21.4 percent versus 7.3 percent and 9.5 percent among Medicaid enrollees and Medicaid eligibles with private insurance, respectively). The Medicaid-eligible uninsured were also more likely than adults in either insured comparison group to have been unable to afford needed prescription medicines, though only the difference relative to the Medicaid-eligible privately insured was statistically significant.

Whereas the Medicaid-eligible uninsured were significantly more likely than the Medicaid-eligible insured to have faced barriers to needed care and medicines, they tended to be less likely than the two

uninsured comparison groups to face such barriers. Note, however, that these latter differences were in most cases small, and none of these differences was significantly different from zero.

FIGURE 1
Access to Care among Medicaid-Eligible Uninsured and Selected Insured and Uninsured Comparison Groups, 2014–18



Source: Authors’ calculations from the Medical Expenditure Panel Survey Household Component (MEPS- HC), 2014–18.
 *Statistically significantly different from the Medicaid-eligible uninsured group at the 5 percent level. **Statistically significantly different from the Medicaid-eligible uninsured group at the 1 percent level.

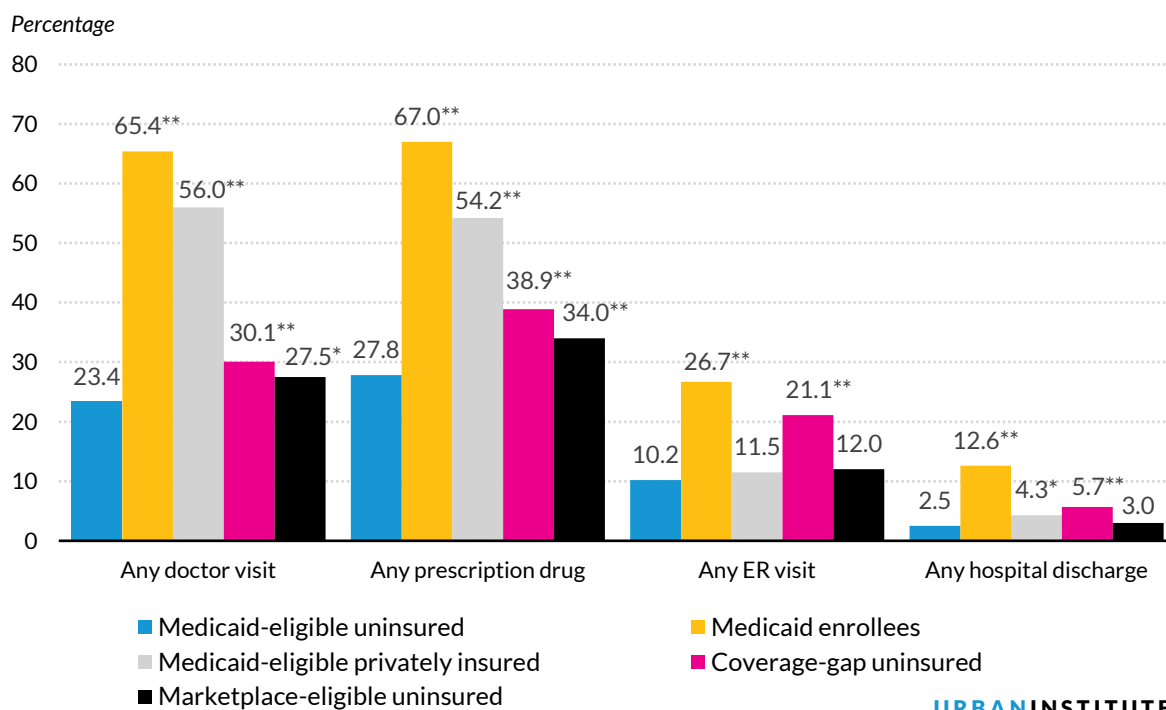
Utilization

Compared with Medicaid enrollees, the Medicaid-eligible uninsured were substantially less likely during the year to have had a doctor visit (23.4 versus 65.4 percent), a prescription medicine fill (27.8 versus 67.0 percent), an emergency room visit (10.2 versus 26.7 percent), or an inpatient hospital stay (2.5 versus 12.6 percent) (figure 2). These differences are perhaps not surprising, given that Medicaid enrollees were more likely to have multiple chronic conditions or to have reported fair or poor physical or mental health.

Also, when interpreting the emergency room and hospital stay differences, we note that a Medicaid-eligible person who was uninsured when he or she sought hospital-based care would often

have been enrolled in Medicaid by the hospital, thereby becoming a member of the enrollee group in our analysis rather than the eligible uninsured group and widening the observed difference. It is perhaps more noteworthy, therefore, that we also observed markedly lower rates of doctor visits and prescription drug use among Medicaid-eligible uninsured adults than among the healthier adults who were eligible for Medicaid and covered with private insurance. In contrast, utilization differences between adults who were Medicaid-eligible uninsured and those in the two uninsured comparison groups were smaller and sometimes not significantly different from zero.

FIGURE 2
Use of Medical Care among Medicaid-Eligible Uninsured and Selected Insured and Uninsured Comparison Groups, 2014–18



Source: Authors' calculations from the Medical Expenditure Panel Survey Household Component (MEPS-HC), 2014–18.
 *Statistically significantly different from the Medicaid-eligible uninsured group at the 5 percent level. **Statistically significantly different from the Medicaid-eligible uninsured group at the 1 percent level.

Spending and Financial Burdens

Despite having less access to care and lower utilization, uninsured Medicaid-eligible adults spend more money out of pocket on health care than their enrolled counterparts (figure 3). The average out-of-pocket spending of Medicaid-eligible uninsured adults was \$315, which was higher than that of

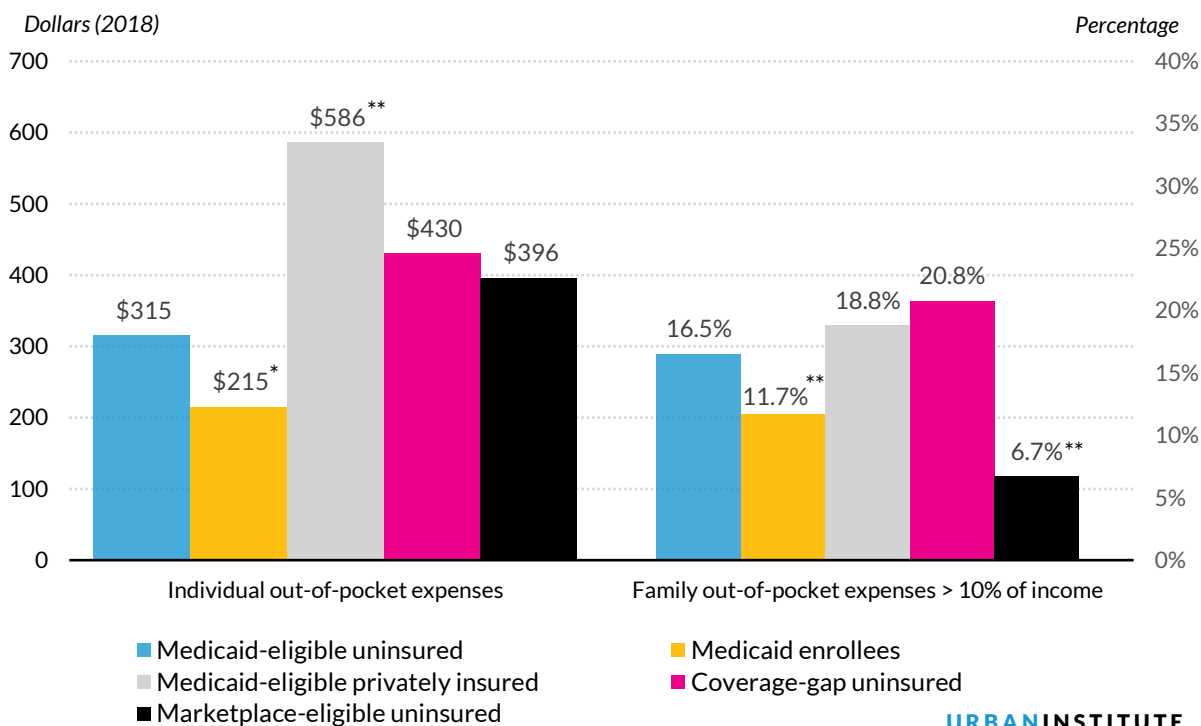
Medicaid enrollees (\$215). The amount spent by Medicaid enrollees includes spending for dental care, prescription drugs, and, for part-year enrollees, health care services used during months not enrolled.

Moreover, for 16.5 percent of uninsured eligibles, family out-of-pocket health care spending amounted to 10 percent or more of family income, while 11.7 percent of Medicaid enrollees had a similar burden of health care spending. Medicaid-eligible adults with private coverage had the highest out-of-pocket spending on care. Despite this, and despite family out-of-pocket spending that was also substantially larger than that of the other groups (appendix A), the frequency of 10 percent burdens among this group was only slightly (and not significantly) higher than among the uninsured Medicaid-eligible group (18.8 versus 16.5 percent).

The highest and lowest burden frequencies were among the two uninsured comparison groups: 20.8 percent of the coverage-gap uninsured and 6.7 percent among low-income adults who were uninsured despite being eligible for Marketplace subsidies. This difference in 10 percent burden frequency was primarily attributable to the difference in income (the former being adults below FPL and the latter being between 100 and 200 percent of FPL). Family out-of-pocket spending on care for the two groups was nearly the same (appendix A).

FIGURE 3

Average Out-of-Pocket Spending and Percentage with Family Out-of-Pocket Spending over 10 Percent of Income among Medicaid-Eligible Uninsured and Selected Insured and Uninsured Comparison Groups, 2014–18



Source: Authors’ calculations from the Medical Expenditure Panel Survey Household Component (MEPS-HC), 2014–18.

Note: The left axis in dollars applies to the first set of bars (individual out-of-pocket expenses). The right axis in percent applies to the second set of bars (share with family out-of-pocket expenses exceeding 10 percent of income).

*Statistically significantly different from the Medicaid-eligible uninsured group at the 5 percent level. **Statistically significantly different from the Medicaid-eligible uninsured group at the 1 percent level.

Multivariate Analysis

Given the large socioeconomic and health status differences in table 1, we conducted multivariate analyses of all access, utilization, and spending outcomes (appendix A). Adjusting for observable differences had only modest effects on our results. The adjusted and unadjusted differences all had the same signs and generally had similar magnitudes. Many of the unadjusted differences in outcomes we observed were large, so controlling for socioeconomic and health status differences had little impact on our results, despite the large differences shown in table 1. One exception was that adjusting for observable factors, including the apparent adverse selection into Medicaid based on health status, tended to narrow (but not eliminate) the utilization differences between Medicaid-eligible adults who enrolled in Medicaid versus those who remained uninsured.

At the same time, multivariate adjustment tended to widen the differences in access to care we observed between these two groups. Intuitively, the Medicaid-eligible uninsured would have experienced even more barriers to care and an even larger difference relative to Medicaid enrollees, if they had had the same health status and other characteristics of that group. Similarly, adjusting for observable differences narrowed the utilization differences between our focus group and both groups of ineligible uninsured adults, with only the difference in emergency room visits remaining statistically significant.

Discussion

Our study compared adults who were Medicaid eligible but uninsured with four other groups of low-income adults. Compared with Medicaid enrollees and Medicaid-eligible adults who had private coverage, the Medicaid-eligible uninsured were less likely to have a usual source of care, were more likely to face financial barriers to needed care, had lower utilization of care, and had a higher prevalence of high out-of-pocket burdens.

The other two comparison groups were comprised of uninsured adults: those in the coverage gaps of their nonexpansion states and those below 200 percent of FPL who were eligible for subsidized Marketplace coverage if purchased during the open enrollment period. Unlike adults who were Medicaid eligible but uninsured, uninsured adults in these two comparison groups lacked provisional coverage, insofar as they could not have enrolled midyear in Medicaid (or subsidized Marketplace) coverage should the need have arisen. Despite this difference, we found broadly similar patterns of outcomes across the three groups of uninsured adults.

It is important to clarify that our results are descriptive. Even our multivariate results, controlling as they do for observable differences including health status, age, and gender, do not address the possibility of unobserved differences driving both the sorting of adults across the five groups and the outcomes we observed. Selection on unobserved characteristics is likely to be particularly severe in the case in which a Medicaid-eligible adult has an adverse health shock that results in hospital-based care, which in turn can often lead to the adult being enrolled in Medicaid.

A randomized trial or natural experiment is the only approach to convincingly explain how the receipt of Medicaid coverage would affect people who are eligible but not enrolled in terms of changes to their access to care, utilization, and other related outcomes. The Oregon Health Insurance Experiment randomly assigned adults on a Medicaid waiting list to receive coverage, finding results qualitatively similar to ours with respect to increased utilization and reductions in financial strain (as measured by debt collection) (Finkelstein et al. 2012). Unfortunately, no similar study has been conducted on persons who did not apply for coverage despite being eligible.

Although we recognize that differences in unmeasured characteristics might exist between our focal group and each of the four comparison groups, it is important to note that controlling for a rich set of observable characteristics had little effect on our results. In fact, doing so strengthened some of our findings—modestly increasing the gaps in access to care and high expenditure burdens between

Medicaid-eligible uninsured adults and Medicaid enrollees, while also modestly narrowing some of the differences across the three uninsured groups.

Intuitively, compared with Medicaid enrollees, the Medicaid-eligible uninsured had observable reasons for needing less medical care (especially much better health status). To the extent that lower need played a role in the Medicaid-eligible uninsured not enrolling, it was all the more striking that they so often reported financial barriers to needed care and financial burdens from obtaining such care. Similarly, the Medicaid-eligible uninsured had better health status than the coverage-gap uninsured, because the former had been self-selected, unlike the latter. Correcting for this difference helped to reduce the extent to which our focal group used less care than the coverage-gap group.

In sum, we interpret our findings as supporting the conclusion that Medicaid-eligible uninsured adults have outcomes much more like other low-income adults who are uninsured than like low-income adults with insurance. Our results, therefore, argue against viewing Medicaid-eligible uninsured adults as having substantially more coverage than other uninsured adults. While Medicaid-eligible uninsured adults do have contingent coverage in the event they go to the hospital, for health care needs below that threshold, our research suggests this group faces barriers to care, and has access problems, reduced utilization, and out-of-pocket spending burdens similar to other uninsured groups. Perhaps more importantly for policy, our results highlight the gains in access to care and utilization, and reduced out-of-pocket spending burdens, that may arise from steps to increase Medicaid enrollment and improve retention among the eligible population.

Given the current administration's focus on health equity,³ it is also worth highlighting that the Medicaid-eligible uninsured are not only low-income, but also, as we showed, more likely to be Black (non-Hispanic) and Hispanic than the general US resident population. Therefore, an added benefit of policies that promote enrollment and retention among Medicaid-eligible adults is improved health equity.

Appendix A. Analysis of Sample Populations and Multivariate Regression Results

TABLE A.1

Socioeconomic Characteristics and Health Status of Medicaid Eligible Uninsured Adults and Selected Comparison Groups With and Without Insurance, 2014–18

| | Medicaid-eligible uninsured (SE) | Medicaid enrollees (SE) | Medicaid-eligible privately insured (SE) | Coverage-gap uninsured (SE) | Marketplace-eligible uninsured (SE) |
|---------------------------|----------------------------------|-------------------------|--|-----------------------------|-------------------------------------|
| Sex (%) | | | | | |
| Female | 41.5 (1.5) | 61.3** (0.8) | 50.8** (1.2) | 43.8 (1.5) | 42.2 (1.3) |
| Race/ethnicity (%) | | | | | |
| White (non-Hispanic) | 48.1 (2.1) | 50.1 (1.6) | 62.9** (1.7) | 44.8 (2.8) | 50.5 (2.2) |
| Black (non-Hispanic) | 18.4 (1.2) | 20.9* (1.1) | 10.3** (0.7) | 29.1** (2.6) | 19.9 (1.7) |
| Hispanic | 23.7 (1.5) | 19.7* (1.1) | 14.3** (1.0) | 18.6 (2.6) | 24.0 (1.8) |
| Other (non-Hispanic) | 9.8 (1.3) | 9.3 (0.7) | 12.6 (1.3) | 7.5 (1.7) | 5.6** (0.8) |
| Age group (%) | | | | | |
| 19–34 | 57.5 (1.9) | 51.1** (0.9) | 71.7** (1.2) | 46.2** (1.7) | 46.1** (1.7) |
| 35–49 | 23.7 (1.5) | 26.4 (0.8) | 13.4** (0.9) | 26.5 (1.8) | 27.3 (1.6) |
| 50–64 | 18.9 (1.4) | 22.5** (0.7) | 14.9* (0.9) | 27.3** (1.7) | 26.6** (1.5) |
| Education (%) | | | | | |
| No high school | 20.5 (2.0) | 24.3 (0.8) | 11.9** (0.8) | 22.6 (1.6) | 15.8* (1.0) |
| High school/GED | 40.7 (1.8) | 42.1 (0.9) | 34.2** (1.3) | 47.7* (2.2) | 47.7** (1.6) |
| Some college | 38.8 (1.8) | 33.6** (0.9) | 54** (1.4) | 29.7** (1.6) | 36.5 (1.6) |
| Income group (%) | | | | | |
| ≤50% of FPL | 25.6 (1.7) | 26.1 (0.8) | 12.7** (0.9) | 30.4* (1.5) | 0.7** (0.2) |
| 51–100% of FPL | 21 (1.5) | 28.6** (0.8) | 13.9** (0.9) | 39.9** (1.7) | 2.3** (0.4) |
| 101–150% of FPL | 20.8 (1.8) | 20.1 (0.6) | 17.4 (0.9) | 12.0** (1.0) | 27.2** (1.2) |
| >150% of FPL | 32.6 | 25.3** | 55.9** | 17.7** | 69.8** |

| | Medicaid-eligible uninsured (SE) | Medicaid enrollees (SE) | Medicaid-eligible privately insured (SE) | Coverage- gap uninsured (SE) | Marketplace- eligible uninsured (SE) |
|-----------------------------|--|-------------------------------|---|---------------------------------------|---|
| | (1.8) | (0.9) | (1.4) | (1.5) | (1.3) |
| Census region (%) | | | | | |
| Northeast | 19.7 (1.7) | 23.1 (1.4) | 25.1* (1.7) | 2.5** (0.8) | 8.2** (1.4) |
| Midwest | 26.4 (2.0) | 23.3 (1.5) | 25.6 (1.7) | 10.3** (1.4) | 14.8** (1.3) |
| South | 23.9 (2.2) | 22.0 (1.7) | 15.8** (1.9) | 84.0** (1.9) | 62.8** (1.9) |
| West | 30 (2.0) | 31.6 (2.3) | 33.4 (1.8) | 3.2** (1.2) | 14.2** (1.2) |
| Survey year (%) | | | | | |
| 2014 | 27.8 (1.6) | 18.9** (0.7) | 21.5** (1.1) | 27.5 (1.5) | 29.1 (1.5) |
| 2015 | 22.6 (1.4) | 21.0 (0.6) | 21.6 (1.1) | 21.2 (1.2) | 21.5 (1.1) |
| 2016 | 20.1 (1.2) | 20.6 (0.7) | 21.8 (1.0) | 18.9 (1.1) | 18.3 (1.3) |
| 2017 | 15.4 (1.2) | 20.7** (0.6) | 17.4 (0.9) | 17.6 (1.3) | 15.6 (1.1) |
| 2018 | 14.1 (1.2) | 18.8** (1.0) | 17.7* (1.1) | 14.8 (1.5) | 15.5 (1.1) |
| Health status (%) | | | | | |
| Fair/Poor health | 12.4 (1.1) | 24.8** (0.7) | 8.3** (0.7) | 21.4** (1.4) | 12.3 (1.0) |
| Fair/Poor mental health | 9.5 (1.1) | 19.3** (0.6) | 7.8 (0.7) | 16.9** (1.4) | 7.6 (0.7) |
| Multiple chronic conditions | 12 (1.1) | 26.3** (0.8) | 10.3 (0.8) | 19.2** (1.7) | 14.7 (1.3) |
| Other variables | | | | | |
| Married (%) | 20.8 (1.6) | 22.2 (0.9) | 19.5 (1.1) | 24.9 (1.8) | 34.2** (1.5) |
| Employed (%) | 47.4 (1.6) | 40.6** (0.8) | 59.2** (1.4) | 50.3 (1.7) | 76.4** (1.3) |
| Children (no.) | 0.6 (0.0) | 0.9** (0.0) | 0.4** (0.0) | 0.5 (0.1) | 0.6 (0.0) |
| Living in an MSA (%) | 84.3 (1.8) | 82.4 (2.0) | 88.2** (1.4) | 79.1 (2.4) | 80.4 (1.8) |

Source: Authors' calculation from the Medical Expenditure Panel Survey Household Component (MEPS-HC), 2014–18.

Notes: n = 19,048. Estimates are population weighted. For all analysis groups, the samples are restricted to citizen adults ages 19 to 64. The samples of Medicaid enrollees and Medicaid-eligible privately insured also exclude those with Medicare or other public insurance. Chronic conditions include diabetes, asthma, high blood pressure, stroke, emphysema, arthritis, cancer, chronic bronchitis, and heart diseases (coronary heart disease, angina, myocardial infarction, or any other heart condition or heart disease).

FPL = federal poverty level; HS = high school; MSA=metropolitan statistical area.

**Statistically significantly different from zero at the 1% level.

*Statistically significantly different from zero at the 5% level.

TABLE A.2

Health Care Access, Utilization, and Spending among Uninsured Adults Eligible for Medicaid and Adult Medicaid Enrollees, 2014–18

| | Medicaid- eligible uninsured (SE) | Medicaid enrollees (SE) | Difference (SE) | Adjusted difference (SE) |
|--|--|-------------------------------|---------------------|--------------------------------|
| Access | | | | |
| Has a usual source of care (%) ^a | 37.0 (1.9) | 69.9 (0.8) | -32.9** (1.9) | -27.5** (1.8) |
| Could not afford medical care ^b (%) | 14.3 (3.3) | 6.0 (0.9) | 8.3* (3.5) | 9.7** (3.7) |
| Delayed medical care because of cost ^b (%) | 21.4 (4.3) | 7.3 (0.9) | 14.0** (4.4) | 15.4** (4.4) |
| Could not afford prescription medicine ^b (%) | 8.5 (2.3) | 5.0 (0.8) | 3.6 (2.5) | 5.7* (2.4) |
| Utilization^a | | | | |
| Any doctor visit (%) | 23.4 (1.4) | 65.4 (0.7) | -41.9** (1.6) | -33.6** (1.6) |
| Doctor visits (no.) | 0.7 (0.1) | 4.2 (0.1) | -3.5** (0.2) | -2.5** (0.1) |
| Any prescription drug (%) | 27.8 (1.5) | 67.0 (0.8) | -39.2** (1.7) | -30.0** (1.6) |
| Any ER visit (%) | 10.2 (1.0) | 26.7 (0.6) | -16.5** (1.1) | -11.7** (1.1) |
| Any hospital discharge (%) | 2.5 (0.6) | 12.6 (0.5) | -10.1** (0.8) | -6.6** (0.7) |
| Spending^{a, c} | | | | |
| Total health care spending (\$) | 2,019 (949) | 6,312 (257) | -4,293** (978) | -2,493* (977) |
| Family total health care spending (\$) | 3,891 (1,003) | 9,419 (379) | -5,529** (1,066) | -2,782** (1,060) |
| Out-of-pocket health care spending (\$) | 315 (35) | 215 (19) | 100* (40) | 150** (45) |
| Family out-of-pocket health care spending (\$) | 555 (65) | 330 (25) | 225** (70) | 296** (75) |
| Family out-of-pocket spending > 10 percent of income (%) | 16.5 (1.4) | 11.7 (0.5) | 4.7** (1.5) | 6.8** (1.3) |
| Family out-of-pocket spending > 20 percent of income (%) | 11.7 (1.2) | 8.4 (0.5) | 3.3* (1.3) | 4.3** (1.3) |

Source: Authors' calculation from the Medical Expenditure Panel Survey Household Component (MEPS-HC), 2014–18.

Notes: Estimates are population weighted, and standard errors and statistical significance of differences and adjusted differences take into account the complex survey design of the MEPS-HC. The samples are restricted to citizen adults ages 19 to 64 for both Medicaid enrollees and Medicaid-eligible uninsured. The sample of Medicaid enrollees also excludes those with Medicare or other public insurance. Adjusted differences are computed using linear regression models that control for survey year, sex (male/female), age groups (19–34, 35–49, 50–64), interactions of sex and age groups, race/ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic, other non-Hispanic), federal poverty level ($\leq 50\%$ of FPL, 51–100% of FPL, 101–150% of FPL, >150% of FPL), education (no high school diploma, high school diploma/GED, some college), employment status (currently employed or not), marital status (married or not married), census region (Northeast, Midwest, South, West), whether the adult lives in a metropolitan statistical area (MSA), number of children, self-reported fair/poor health, self-reported fair/poor mental health, and presence of multiple chronic conditions. Where applicable, the variables represented the status at the end of the calendar year or at the last interview of the calendar year. Chronic conditions included diabetes, asthma, high blood pressure, stroke, emphysema, arthritis, cancer, chronic bronchitis, and heart diseases (coronary heart disease, angina, myocardial infarction, or any other heart

condition or heart disease). To assess whether our results were sensitive to choice of regression models, we ran alternative regression models for our outcomes. Specifically, we ran logistic regressions models for all dichotomous outcomes, two-part models for family out-of-pocket spending (probit and GLMs), and Poisson and negative binomial regression models for the number of doctor visits [see Davidoff, Garrett, and Yemane 2000 and Gruber and Levy 2009]. The resulting adjusted differences from alternative models were similar to those from the linear regression models, in terms of the directions, statistical significance, and magnitudes.

^a $n = 1,856$ for Medicaid-eligible uninsured and $n = 9,794$ for Medicaid enrollees.

^b $n = 217$ for Medicaid-eligible uninsured and $n = 1,523$ for Medicaid enrollees, as data for these outcomes are only available for the survey year 2018.

^c Families were defined as health insurance eligibility units (HIEUs), comprising adults, their spouses, and co-residing children younger than 19. All dollar values were adjusted to 2018 dollars using the Consumer Price Index for All Urban Consumers (CPI-U).

* Statistically significantly different from the Medicaid-eligible uninsured group at the 5 percent level.

** Statistically significantly different from the Medicaid-eligible uninsured group at the 1 percent level.

TABLE A.3

Health Care Access, Utilization, and Spending among Uninsured and Privately Insured Adults Eligible for Medicaid, 2014–18

| | Medicaid-eligible uninsured (SE) | Medicaid-eligible privately insured (SE) | Difference (SE) | Adjusted difference (SE) |
|--|--|---|---------------------|--------------------------------|
| Access | | | | |
| Has a usual source of care (%) ^a | 37.0 (1.9) | 66.8 (1.3) | -29.8** (2.2) | -28.0** (2.0) |
| Could not afford medical care ^b (%) | 14.3 (3.3) | 3.6 (0.9) | 10.7** (3.5) | 10.0** (3.4) |
| Delayed medical care because of cost ^b (%) | 21.4 (4.3) | 9.5 (2.6) | 11.8** (4.5) | 10.9* (4.5) |
| Could not afford prescription medicine ^b (%) | 8.5 (2.3) | 2.5 (0.8) | 6.0* (2.5) | 5.4* (2.3) |
| Utilization^a | | | | |
| Any doctor visit (%) | 23.4 (1.4) | 56.0 (1.3) | -32.6** (1.9) | -31.2** (1.8) |
| Doctor visits (no.) | 0.7 (0.1) | 2.3 (0.1) | -1.6** (0.2) | -1.6** (0.2) |
| Any prescription drug (%) | 27.8 (1.5) | 54.2 (1.2) | -26.4** (2.0) | -26.2** (1.8) |
| Any ER visit (%) | 10.2 (1.0) | 11.5 (0.8) | -1.3 (1.3) | -3.0* (1.2) |
| Any hospital discharge (%) | 2.5 (0.6) | 4.3 (0.4) | -1.8* (0.7) | -2.3** (0.7) |
| Spending^{a, c} | | | | |
| Total health care spending (\$) | 2,019 (949) | 3,902 (323) | -1,883 (1,008) | -2,129* (935) |
| Family total health care spending (\$) | 3,891 (1,003) | 8,450 (547) | -4,560** (1,156) | -4,542** (1,086) |
| Out-of-pocket health care spending (\$) | 315 (35) | 586 (43) | -271** (58) | -225** (60) |
| Family out-of-pocket health care spending (\$) | 555 (65) | 1,188 (77) | -633** (102) | -523** (106) |
| Family out-of-pocket spending > 10 percent of income (%) | 16.5 (1.4) | 18.8 (1.1) | -2.4 (1.6) | -4.6** (2.5) |
| Family out-of-pocket spending > 20 percent of income (%) | 11.7 (1.2) | 13.0 (0.9) | -1.3 (1.4) | -3.5** (1.3) |

Source: Authors' calculation from the Medical Expenditure Panel Survey Household Component (MEPS-HC), 2014–18.

Notes: Estimates are population weighted, and standard errors and statistical significance of differences and adjusted differences take into account the complex survey design of the MEPS-HC. The samples are restricted to citizen adults ages 19 to 64 for both Medicaid-eligible uninsured and privately insured. The sample of Medicaid eligible privately insured also excludes those with Medicare or other public insurance. Adjusted differences are computed using linear regression models that control for survey year, sex (male/female), age groups (19–34, 35–49, 50–64), interactions of sex and age groups, race/ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic, other non-Hispanic), federal poverty level ($\leq 50\%$ of FPL, 51–100% of FPL, 101–150% of FPL, >150% of FPL), education (no high school diploma, high school diploma/GED, some college), employment status (currently employed or not), marital status (married or not married), census region (Northeast, Midwest, South, West), whether the adult lives in a metropolitan statistical area (MSA), number of children, self-reported fair/poor health, self-reported fair/poor mental health, and presence of multiple chronic conditions. Where applicable, the variables represented the status at the end of the calendar year or at the last interview of the calendar year. Chronic conditions included diabetes, asthma, high blood pressure,

stroke, emphysema, arthritis, cancer, chronic bronchitis, and heart diseases (coronary heart disease, angina, myocardial infarction, or any other heart condition or heart disease). To assess whether our results were sensitive to choice of regression models, we ran alternative regression models for our outcomes. Specifically, we ran logistic regressions models for all dichotomous outcomes, two-part models for family out-of-pocket spending (probit and GLMs), and Poisson and negative binomial regression models for the number of doctor visits [see Davidoff, Garrett, and Yemane 2000 and Gruber and Levy 2009]. The resulting adjusted differences from alternative models were similar to those from the linear regression models, in terms of the directions, statistical significance, and magnitudes.

^a $n = 1,856$ for Medicaid-eligible uninsured and $n = 3,398$ for Medicaid-eligible privately insured.

^b $n = 217$ for Medicaid-eligible uninsured and $n = 534$ for Medicaid-eligible privately insured, as data for these outcomes are only available for the survey year 2018.

^c Families were defined as health insurance eligibility units (HIEUs), comprising adults, their spouses, and co-residing children younger than 19. All dollar values were adjusted to 2018 dollars using the Consumer Price Index for All Urban Consumers (CPI-U).

^{**} Statistically significantly different from zero at the 1% level.

^{*} Statistically significantly different from zero at the 5% level.

TABLE A.4

Health Care Access, Utilization, and Spending among Coverage-Gap Uninsured Adults and Adults Eligible for Medicaid but Uninsured, 2014–18

| | Medicaid-eligible uninsured (SE) | Coverage-gap uninsured (SE) | Difference (SE) | Adjusted difference (SE) |
|--|----------------------------------|-----------------------------|------------------|--------------------------|
| Access | | | | |
| Has a usual source of care ^a (%) | 37.0 (1.9) | 38.9 (2.0) | -1.9 (2.7) | -3.4 (2.6) |
| Could not afford medical care ^b (%) | 14.3 (3.3) | 23.0 (3.0) | -8.7 (4.8) | -9.1 (5.0) |
| Delayed medical care because of cost ^b (%) | 21.4 (4.3) | 26.8 (3.0) | -5.4 (5.2) | -5.7 (5.3) |
| Could not afford prescription medicine ^b (%) | 8.5 (2.3) | 12.0 (2.3) | -3.5 (3.4) | -0.3 (3.3) |
| Utilization^a | | | | |
| Any doctor visit (%) | 23.4 (1.4) | 30.1 (1.9) | -6.7** (2.4) | -3.0 (2.3) |
| Doctor visits (no.) | 0.7 (0.1) | 1.1 (0.1) | -0.4** (0.1) | 0.1 (0.2) |
| Any prescription drug (%) | 27.8 (1.5) | 38.9 (2.1) | -11.1** (2.6) | -3.9 (2.2) |
| Any ER visit (%) | 10.2 (1.0) | 21.1 (1.8) | -10.9** (2.0) | -7.4** (1.8) |
| Any hospital discharge (%) | 2.5 (0.6) | 5.7 (0.8) | -3.1** (1.0) | -0.7 (0.9) |
| Spending^{a, c} | | | | |
| Total health care spending (\$) | 2,019 (949) | 1,988 (304) | 31 (993) | 966 (1,005) |
| Family total health care spending (\$) | 3,891 (1,003) | 3,936 (428) | -46 (1,079) | 429 (1,105) |
| Out-of-pocket health care spending (\$) | 315 (35) | 430 (51) | -115 (62) | -97 (65) |
| Family out-of-pocket health care spending (\$) | 555 (65) | 634 (82) | -79 (103) | -128 (106) |
| Family out-of-pocket spending > 10 percent of income (%) | 16.5 (1.4) | 20.8 (1.8) | -4.3 (2.2) | -3.3 (2.1) |
| Family out-of-pocket spending > 20 percent of income (%) | 11.7 (1.2) | 16.0 (1.7) | -4.3* (2.2) | -3.5 (2.1) |

Source: Authors' calculation from the Medical Expenditure Panel Survey Household Component (MEPS-HC), 2014–18.

Notes: Estimates are population weighted, and standard errors and statistical significance of differences and adjusted differences take into account the complex survey design of the MEPS-HC. The samples are restricted to citizen adults ages 19 to 64 for both Medicaid-eligible uninsured and coverage-gap uninsured (Medicaid-ineligible uninsured in nonexpansion states with income <100% of the federal poverty level). Adjusted differences are computed using linear regression models that control for survey year, sex (male/female), age groups (19–34, 35–49, 50–64), interactions of sex and age groups, race/ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic, other non-Hispanic), federal poverty level ($\leq 50\%$ of FPL, 51–100% of FPL, 101–150% of FPL, >150% of FPL), education (no high school diploma, high school diploma/GED, some college), employment status (currently employed or not), marital status (married or not married), census region (Northeast, Midwest, South, West), whether the adult lives in a metropolitan statistical area (MSA), number of children, self-reported fair/poor health, self-reported fair/poor mental health, and presence of multiple chronic conditions. Where applicable, the variables represented the status at the end of the calendar year or at the last interview of the calendar year. Chronic conditions included diabetes, asthma, high blood pressure, stroke, emphysema, arthritis, cancer, chronic bronchitis, and heart diseases (coronary heart disease, angina, myocardial infarction,

or any other heart condition or heart disease). To assess whether our results were sensitive to choice of regression models, we ran alternative regression models for our outcomes. Specifically, we ran logistic regressions models for all dichotomous outcomes, two-part models for family out-of-pocket spending (probit and GLMs), and Poisson and negative binomial regression models for the number of doctor visits [see Davidoff, Garrett, and Yemane 2000 and Gruber and Levy 2009]. The resulting adjusted differences from alternative models were similar to those from the linear regression models, in terms of the directions, statistical significance, and magnitudes.

^a $n = 1,856$ for Medicaid-eligible uninsured and $n = 1,829$ for Medicaid-ineligible uninsured in nonexpansion states with income <100% of FPL.

^b $n = 217$ for Medicaid-eligible uninsured and $n = 236$ for Medicaid-ineligible uninsured in nonexpansion states with income <100% of FPL, as data for these outcomes are only available for the survey year 2018.

^c Families were defined as health insurance eligibility units (HIEUs), comprising adults, their spouses, and co-residing children younger than 19. All dollar values were adjusted to 2018 dollars using the Consumer Price Index for All Urban Consumers (CPI-U).

^{**} Statistically significantly different from zero at the 1% level.

^{*} Statistically significantly different from zero at the 5% level.

TABLE A.5

Health Care Access, Utilization, and Spending among Marketplace-Eligible Uninsured and Adults Eligible for Medicaid but Uninsured, 2014–18

| | Medicaid- eligible uninsured (SE) | Marketplace- eligible uninsured (SE) | Difference (SE) | Adjusted difference (SE) |
|--|--|---|--------------------|--------------------------------|
| Access | | | | |
| Has a usual source of care ^a (%) | 37.0 (1.9) | 38.6 (1.7) | -1.6 (2.5) | 0.6 (2.4) |
| Could not afford medical care ^b (%) | 14.3 (3.3) | 19.6 (2.9) | -5.3 (4.0) | -7.4 (3.9) |
| Delayed medical care because of cost ^b (%) | 21.4 (4.3) | 23.8 (3.2) | -2.5 (5.0) | -3.9 (5.1) |
| Could not afford prescription medicine ^b (%) | 8.5 (2.3) | 7.9 (1.7) | 0.7 (2.9) | 0.8 (2.8) |
| Utilization^a | | | | |
| Any doctor visit (%) | 23.4 (1.4) | 27.5 (1.4) | -4.1* (1.9) | -1.7 (1.9) |
| Number of doctor visits | 0.7 (0.1) | 1.0 (0.1) | -0.3* (0.1) | -0.3 (0.2) |
| Any prescription drug (%) | 27.8 (1.5) | 34.0 (1.6) | -6.2** (2.1) | -2.8 (1.9) |
| Any ER visit (%) | 10.2 (1.0) | 12.0 (1.1) | -1.8 (1.5) | -4.4** (1.5) |
| Any hospital discharge (%) | 2.5 (0.6) | 3.0 (0.4) | -0.4 (0.7) | -1.2 (0.8) |
| Spending^{a, c} | | | | |
| Total health care spending (\$) | 2,019 (949) | 1,535 (211) | 484 (974) | 214 (836) |
| Family total health care spending (\$) | 3,891 (1,003) | 3,735 (511) | 156 (1,121) | 627 (1,052) |
| Out-of-pocket health care spending (\$) | 315 (35) | 396 (33) | -81 (46) | -49 (48) |
| Family out-of-pocket health care spending (\$) | 555 (65) | 632 (52) | -77 (78) | 63 (85) |
| Family out-of-pocket spending > 10 percent of income (%) | 16.5 (1.4) | 6.7 (0.8) | 9.8** (1.5) | 2.6 (1.5) |
| Family out-of-pocket spending > 20 percent of income (%) | 11.7 (1.2) | 3.5 (0.6) | 8.2** (1.3) | 1.6 (1.4) |

Source: Authors' calculation from the Medical Expenditure Panel Survey Household Component (MEPS-HC), 2014–18.

Notes: Estimates are population weighted, and standard errors and statistical significance of differences and adjusted differences take into account the complex survey design of the MEPS-HC. The samples are restricted to citizen adults ages 19 to 64 for both Medicaid-eligible uninsured and for Marketplace-eligible uninsured (i.e., Medicaid-ineligible uninsured with income at or above 100% and below 200% of the federal poverty level). Adjusted differences are computed using linear regression models that control for survey year, sex (male/female), age groups (19–34, 35–49, 50–64), interactions of sex and age groups, race/ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic, other non-Hispanic), federal poverty level ($\leq 50\%$ of FPL, 51–100% of FPL, 101–150% of FPL, >150% of FPL), education (No high school diploma, high school diploma/GED, some college), employment status (currently employed or not), marital status (married or not married), census region (Northeast, Midwest, South, West), whether the adult lives in a metropolitan statistical area (MSA), number of children, self-reported fair/poor health, self-reported fair/poor mental health, and presence of multiple chronic conditions. Where applicable, the variables represented the status at the end of the calendar year or at the last interview of the calendar year. Chronic conditions included diabetes, asthma, high blood pressure, stroke, emphysema, arthritis, cancer, chronic bronchitis, and heart diseases (coronary heart disease, angina, myocardial

infarction, or any other heart condition or heart disease). To assess whether our results were sensitive to choice of regression models, we ran alternative regression models for our outcomes. Specifically, we ran logistic regressions models for all dichotomous outcomes, two-part models for family out-of-pocket spending (probit and GLMs), and Poisson and negative binomial regression models for the number of doctor visits [see Davidoff, Garrett, and Yemane 2000 and Gruber and Levy 2009]. The resulting adjusted differences from alternative models were generally quite similar to those from the linear regression models, in terms of the directions, statistical significance, and magnitudes.

^a $n=1,856$ for Medicaid-eligible uninsured and $n = 2,171$ for Medicaid-ineligible uninsured with income at or above 100% and below 200% of FPL.

^b $n = 217$ for Medicaid eligible uninsured and $n = 296$ for Medicaid ineligible uninsured with income at or above 100% and below 200% of FPL, as data for these outcomes are only available for the survey year 2018.

^c Families were defined as health insurance eligibility units (HIEUs), comprising adults, their spouses, and co-residing children younger than 19. All dollar values were adjusted to 2018 dollars using the Consumer Price Index for All Urban Consumers (CPI-U).

^{**} Statistically significantly different from zero at the 1% level.

^{*} Statistically significantly different from zero at the 5% level.

Notes

- ¹ Congressional Budget Office, “Expanding Health Insurance Coverage for Children under Title XXI of the Social Security Act,” memorandum, February 1998, <https://www.cbo.gov/sites/default/files/105th-congress-1997-1998/reports/kids-hi.pdf>, Christen Linke Young, “Retroactive Enrollment: A Feasible Way to Bring Auto-Enrollment to the Individual Market,” *Forefront* (blog), Health Affairs, October 10, 2019, <https://www.healthaffairs.org/doi/10.1377/forefront.20191008.51281/full/>.
- ² Medical Expenditure Panel Survey HC-209, Full-Year Consolidated Data File, Agency for Health Care Research and Quality, 2018, https://meps.ahrq.gov/mepsweb/data_stats/download_data_files_detail.jsp?cboPufNumber=HC-209.
- ³ Brian C. Quinn and Tina J. Kauh, “For Its Health Equity Agenda, the Biden Administration Needs Research That Focuses on Impacted Communities,” *Forefront* (blog), Health Affairs, July 13, 2021, <https://www.healthaffairs.org/doi/10.1377/forefront.20210712.23373>.

References

- Abdus, Salam, Kamila B. Mistry, and Thomas M. Selden. 2015. "Racial and Ethnic Disparities in Services and the Patient Protection and Affordable Care Act." *American Journal of Public Health* 105 (Suppl 5): S668–S675.
- Besharov, Douglas J. 2000. *Testimony on the Effects of Welfare Reform in a Hearing Before the Subcommittee on Human Resources of the Committee on Ways and Means, House of Representatives, 106th Congress, Washington, DC.*
- Buettgens, Matthew, and Jessica Banthin. 2020. "The Health Insurance Policy Simulation Model for 2020." Washington, DC: Urban Institute.
- CBO (Congressional Budget Office). 2020. "Who Went Without Health Insurance in 2019, and Why?" Washington, DC: CBO.
- Cutler, David M., and Jonathan Gruber. 1996. "Does Public Insurance Crowd Out Private Insurance?" *Quarterly Journal of Economics* 111 (2): 391–430.
- Davidoff, Amy J., Bowen Garrett, and Alshadye Yemane. 2000. "Medicaid-Eligible Adults Who Are Not Enrolled." Washington, DC: Urban Institute.
- Decker, Sandra L., Salam Abdus, and Brandy J. Lipton. 2021. "Eligibility for and Enrollment in Medicaid Among Nonelderly Adults after Implementation of the Affordable Care Act." *Medical Care Research and Review* 33655784: March 3.
- Finkelstein, Amy, Sarah Taubman, Bill Wright, Mira Bernstein, Jonathan Gruber, Joseph P. Newhouse, Heidi Allen, and Katherine Baicker. 2012. "The Oregon Health Insurance Experiment: Evidence from the First Year." *Quarterly Journal of Economics* 127 (3): 1057–106.
- Gruber, Jonathan, and Helen Levy. 2009. "The Evolution of Medical Spending Risk." *Journal of Economic Perspectives* 23 (4): 25–48.
- Jacobs, Paul D., Steven C. Hill, and Salam Abdus. 2017. "Adults Are More Likely to Become Eligible for Medicaid during Future Recessions If Their State Expanded Medicaid." *Health Affairs* 36 (1): 32–39.
- Saloner, Brendan, Katherine Hempstead, Karin Rhodes, Daniel Polsky, Clare Pan, and Genevieve M. Kenney. 2018. "Most Primary Care Physicians Provide Appointments, but Affordability Remains a Barrier for the Uninsured." *Health Affairs* 37 (4): 627–34.

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