

RESEARCH REPORT

# Impacts of the ACA's Medicaid Expansion on Health Insurance Coverage and Health Care Access among Young Adults

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# Impacts of the ACA's Medicaid Expansion on Health Insurance Coverage and Health Care Access among Young Adults

Young adults ages 19 to 25 have historically had limited access to both employer-sponsored insurance and public insurance coverage, resulting in the highest rates of uninsurance among all age groups before passage of the Affordable Care Act (ACA) in 2010.<sup>1</sup> Coverage and access to care for young adults improved following the ACA (Lipton, Decker, and Sommers 2017; McMorrow et al. 2015), with specific improvements attributed to the dependent coverage provision (Antwi, Moriya, and Simon 2013; Cantor et al. 2012; Sommers and Kronick 2012; Sommers et al. 2013; Wallace and Sommers 2015). But to date, no study has examined the specific impacts of the ACA's Medicaid expansion on young adult coverage and access to care. In this report, we examine trends between 2011 and 2018 in insurance coverage and access to care for young adults ages 19 to 25 and assess the impact of expanding Medicaid eligibility to young adults. We find the following:

- Between 2011 and 2018, uninsurance rates among young adults fell by nearly half. Though uninsurance rates among young adults declined in all states, effects were greatest in states that expanded Medicaid under the ACA. Overall, ACA Medicaid expansion is associated with a 14 percent decline in uninsurance among young adults, with larger effects for young adults in low-income households.
- Medicaid expansion was associated with larger decreases in uninsurance among Hispanic and non-Hispanic Black young adults, young adults ages 22 to 25 without a college degree, and young adults in low-income households—all groups with high uninsurance rates before ACA implementation. As a result, Medicaid expansion reduced differences in coverage by race/ethnicity, educational attainment, and household income in this age group.
- Between 2011 and 2018, access to health care improved for young adults in both expansion and nonexpansion states. For young adults in low-income households and young adults with

lower educational attainment, Medicaid expansion was associated with an increased likelihood of having a personal doctor. It was also associated with a large decrease in the likelihood of delaying needed care because of cost in the past year among non-Hispanic Black young adults.

ACA Medicaid expansions increased coverage among young adults and improved access to care among those with low incomes and those ages 22 to 25 without a college degree. These findings suggest expanding Medicaid in additional states could further improve coverage and access to care among young adults, particularly those who are socioeconomically disadvantaged.

## Background

### Understanding the Problem

Health care is critically important as young adults transition from adolescence and take on more responsibility for their own health and well-being, building a foundation for their long-term health in adulthood.<sup>2</sup> Yet, young adults receive overall health care, office-based care, and preventive services at low rates (Lau et al. 2013, 2014). Lack of health insurance coverage is one factor that has limited receipt of health care; before the ACA, uninsured young adults ages 20 to 29 were less likely than those with private or public health insurance to have a usual source of care or to have visited a doctor in the past year and were more likely to have had unmet need for medical care (Cohen and Bloom 2010).

Young adults ages 19 to 25 have historically had the highest rates of uninsurance among all age groups. Before the ACA, adolescents in low-income households often aged out of eligibility for public health insurance coverage through Medicaid or the Children's Health Insurance Program as they entered adulthood. Further, the employment patterns of young adults made them less likely than older adults to have an offer of employer-sponsored insurance coverage (Holahan and Kenney 2008). When the ACA passed in 2010, about one-third of young adults ages 19 to 25 were uninsured, more than any other age group.<sup>3</sup>

### Major ACA Provisions That Could Affect Young Adult Coverage and Access to Care

The ACA included numerous provisions that could affect health insurance coverage for young adults. First, it included the dependent coverage provision, allowing young adults up to age 26 to remain

enrolled in a parent's private health insurance plan as a dependent beginning in 2010. To benefit from the dependent coverage provision, a young adult must have a parent with private health insurance coverage, which, on average, likely draws from the upper end of the income distribution.

Second, though not specifically targeted to young adults, the ACA enabled states to expand Medicaid eligibility to nondisabled, nonelderly adults with incomes up to 138 percent of the federal poverty level (FPL). Twenty-five states expanded Medicaid under the ACA by January 1, 2014, and an additional 14 states have expanded or have planned to expand their Medicaid programs under the ACA as of January 1, 2021.<sup>4</sup> Some young adults may have been eligible for Medicaid coverage before the ACA if they were disabled or if they had low household incomes and qualified for eligibility as parents or through pregnancy, though eligibility rules varied across states.<sup>5</sup> Most childless young adults with low household incomes were not eligible for Medicaid before the ACA and would thus benefit the most from Medicaid expansion. Since household income generally increases with age, the ACA Medicaid expansions disproportionately benefit young adults relative to other age groups (Buettgens 2021).

Other 2014 ACA provisions with the potential to increase access to affordable health insurance coverage and care among adults included premium subsidies and cost-sharing reductions for plans on the newly created Marketplaces. The ACA also included an individual mandate, which required individuals to have health insurance or pay a penalty for noncompliance, the penalty for which was reduced to \$0 by Congress effective January 2019 (Kamal et al. 2018). The ACA also included resources for outreach and enrollment efforts to help connect individuals with the new health insurance options.

Considering all ACA coverage provisions, young adults with household incomes below 138 percent of FPL in expansion states were most likely to benefit from Medicaid expansion. Those not eligible for Medicaid with household incomes between 100 and 400 percent of FPL (in nonexpansion states) or between 138 and 400 percent of FPL (in expansion states) were likely to benefit from premium subsidies and cost-sharing reductions for Marketplace coverage. Young adults with privately insured parents, who are disproportionately in higher-income households than those without privately insured parents, were likely to benefit from the dependent coverage provision. Finally, young adults with household incomes below the poverty level in states that did not expand Medicaid fall into the "coverage gap" and are likely not eligible for either Medicaid coverage or subsidized Marketplace coverage under the ACA.

## Documented Effects of ACA Coverage Provisions

Following the implementation of all ACA provisions described above, the uninsurance rate among young adults fell by more than one-third between 2009 and the second quarter of 2014 (McMorrow et al. 2015). Between 2000 and 2014, young adults experienced gains in insurance coverage, having a usual source of care, and visiting a doctor at least once, while the likelihood of visiting an emergency department declined (Lipton, Decker, and Sommers 2017). Studies of the dependent coverage provision, specifically, found it decreased uninsurance among young adults ages 19 to 25 and further improved self-reported health, increased access to health care, and decreased high out-of-pocket health care spending (Antwi, Moriya, and Simon 2013; Barbaresco, Courtemanche, and Qi 2015; Busch, Golberstein, and Meara 2014; Cantor et al. 2012; Sommers et al. 2013; Wallace and Sommers 2015).

Notably, different groups of young adults benefitted differently from provisions within the ACA, with moderate- and high-income young adults gaining coverage under the dependent coverage provisions. Low-income young adults, however, did not experience gains until Medicaid expansion and the availability of Marketplace subsidies, after which high-income young adults did not experience a gain in coverage (McMorrow et al. 2015). Improvement in insurance coverage for young adults continued through 2016, but uninsurance and unmet need for care increased between 2016 and 2017 in states that did not expand Medicaid (Griffith 2020).

An extensive literature has documented the positive impacts of Medicaid expansion on health insurance coverage, access to care, and affordability for non-elderly adults overall, parents, childless adults, women of reproductive age, and other groups, but no research to date has specifically investigated the impact of ACA Medicaid expansion on coverage and access to care for young adults (Courtemanche et al. 2017; Daw and Sommers 2019; Guth, Garfield, and Rudowitz 2020; Johnston et al. 2018; Kaestner et al. 2017; McMorrow et al. 2017; Miller and Wherry 2019; Simon, Soni, and Cawley 2017).

## Purpose of This Study

In this report, we examine changes in coverage and access to care among young adults between 2011 and 2018 and consider how Medicaid expansion may have contributed to observed changes in these outcomes. We investigate the impacts of the ACA Medicaid expansion, specifically, on young adult coverage and access through 2018 by comparing trends in states that did and did not expand Medicaid under the ACA. Our findings are vital to understanding what is at stake if the ACA Medicaid



expansion were to be invalidated by the Supreme Court and provide information on the potential gains if additional states were to take up the Medicaid expansion.

## Data and Methods

### Data

We use two separate datasets for this analysis, one to assess uninsurance and Medicaid coverage among young adults and another to assess health care access and use among young adults.

First, we use data from the 2011–2018 American Community Survey (ACS) to assess rates of uninsurance and Medicaid coverage among young adults ages 19 to 25. The ACS is an annual nationwide survey conducted by the US Census Bureau and collects social, economic, housing, demographic, health insurance coverage, and other household information from more than 3.5 million households each year. We use coverage types reported in the ACS and edited by IPUMS.<sup>6</sup> Health insurance coverage is self-reported at the time of the survey, and respondents can report multiple types of coverage. All young adults who report Medicaid coverage are classified as covered by Medicaid. Young adults who do not report any type of health insurance coverage are classified as uninsured.<sup>7</sup> All analyses are restricted to young adults ages 19 to 25 and weighted using ACS sample weights.

Second, we use data from the 2011–18 Behavioral Risk Factor Surveillance System (BRFSS) to evaluate trends in measures of health care access and use among young adults. The BRFSS is an annual telephonic survey conducted by the Centers for Disease Control and Prevention that assesses health behaviors, chronic conditions, health care access and use, and other health characteristics among adults. Starting in 2011, the BRFSS survey contacted respondents via either landline or cell phone interviews.<sup>8</sup> The BRFSS interviews approximately 400,000 adult respondents each year. We investigate trends in four measures related to health care access and use: whether the respondent received a routine checkup in the past 12 months, had a personal doctor, delayed needed care because of cost in the 12 months, or received a flu shot or nasal spray in the past 12 months. We restrict our analysis to young adults ages 19 to 25, and all estimates are derived using BRFSS sample weights.

## Methods

Our analysis is restricted to states<sup>9</sup> that expanded Medicaid by January 1, 2014, or did not expand Medicaid by 2018, thereby excluding five states that had Medicaid eligibility pathways for nondisabled adults before ACA enactment<sup>10</sup> and seven states that expanded Medicaid under the ACA after January 1, 2014.<sup>11</sup> Thus, our analysis sample includes 19 states that did not expand Medicaid by 2018 and 20 states that expanded Medicaid under the ACA on or before January 1, 2014.<sup>12</sup>

We first describe trends in uninsurance and Medicaid coverage from 2011 through 2018 among all analysis states and by Medicaid expansion status. We then use a difference-in-differences estimation strategy to assess the impact of Medicaid expansion on young adults' uninsurance, Medicaid coverage, and health care access and use. This strategy evaluates the change in outcome measures in Medicaid expansion states relative to nonexpansion states between 2011 and 2013 (the period before Medicaid expansion) and 2015 and 2018 (the period after Medicaid expansion), omitting the 2014 survey year, during which expansion was implemented. The underlying assumption of this model is that nonexpansion states represent counterfactual evidence of what would have occurred in expansion states in the absence of Medicaid expansion. This approach allows us to isolate the impacts of Medicaid expansion on our outcomes of interest from the myriad ACA policies that affected young adult coverage and access in both expansion and nonexpansion states, such as the dependent coverage provision, Marketplace subsidies, and the individual mandate. We discuss our difference-in-differences approach and its limitations in more detail in box 1.

## Limitations

This analysis has several data limitations. Both the ACS and the BRFSS measures are self-reported and subject to recall or other biases. ACS measures of uninsurance and Medicaid coverage are measured with error, likely resulting in an undercount of Medicaid enrollment (Boudreaux et al. 2015; Lynch et al. 2011). Our ACS analysis includes young adults residing in group quarters, representing just over 2 percent of the sample; however, many young adults in group quarters are not included in subanalyses by income, because information on household size used to construct the IPUMS measure of poverty status is missing. Household income is measured with error, particularly for young adults who may reside with non-family members or be supported by family members who live in separate households.

Historically, the BRFSS has had low response rates, resulting in socioeconomic demographic estimates that are distinct at the state level relative to those reported in the decennial census, even after adjustment weights are used to account for nonresponse (Schneider et al. 2012).<sup>13</sup> Finally, the

inability to identify the number of other adults present in a household among some respondents in the BRFSS along with categorical measures of household income results in measurement error in income. Measurement error for income on both surveys prevents this analysis from identifying young adults likely eligible for Medicaid expansion; we instead assess differences between young adults in broad high- and low-income classifications.

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## BOX 1

### Difference-in-Differences Implementation and Limitations

**Difference-in-differences implementation.** Our difference-in-differences models include indicators for state of residence, survey year and, our coefficient of interest, an interaction term between whether a respondent's state of residence expanded Medicaid and whether the period of analysis occurred *after* implementation in 2014. This estimate represents the impact of Medicaid expansion among all young adults in expansion states irrespective of whether the young adults enrolled in Medicaid. We further control for the following:

- respondent's sex,
- respondent's race/ethnicity,
- respondent's age,
- respondent's educational attainment,
- respondent's parental status,
- respondent's marital status, and
- state-level unemployment rates from the US Bureau of Labor Statistics

These controls adjust for demographic and economic factors correlated with our outcomes of interest and may have trended distinctly across expansion and nonexpansion states. All analyses use weighted least squares estimation, and standard errors are clustered at the state of residence.

We estimate our difference-in-differences models on all young adults ages 19 to 25 and among major subgroups in both the ACS and BRFSS. In the ACS, we separately assess the impact of Medicaid expansion on young adult uninsurance rates and Medicaid coverage by sex, race/ethnicity (non-Hispanic white, non-Hispanic Black, and Hispanic young adults), age (19 to 21, 22 to 25), college degree status among young adults ages 22 to 25, and parental status.<sup>14</sup> We also investigate the impact of Medicaid expansion among young adults in households with incomes below 200 percent of FPL, as they are more likely to be affected by Medicaid expansion, and those with household incomes at or above 200 percent of FPL, as they are less likely to be affected by expansion.<sup>15</sup>

In the BRFSS, we assess the impact of Medicaid expansion on young adult health care access by sex, race/ethnicity, age, college degree status among young adults ages 22 to 25, and parental status.

We also investigate the impact of Medicaid expansion by income, first imputing household income using the midpoint of BRFSS categorical income values divided by the number of children in the household plus the adult respondent, then dividing the sample at the median to classify young adults in low- and high-income households.<sup>16</sup>

**Limitations of difference-in-differences approach.** Our difference-in-differences analytic strategy relies on nonexpansion states serving as an appropriate counterfactual for what would have occurred in expansion states in the absence of Medicaid expansion. Though this method accounts for concurrent policy changes in both groups, such as the dependent coverage provision or the availability of Marketplace subsidies, if coverage and access for young adults were trending differently in nonexpansion states than in expansion states before 2014, the results of our analysis would be biased. We limit this concern by controlling for demographic and socioeconomic characteristics, but unobserved omitted variables may bias our estimates, particularly if Medicaid expansion states implemented other policies at the time of expansion, such as outreach and enrollment efforts not taken up by nonexpansion states, or if other ACA provisions initiated in 2014 were implemented differently in expansion states than in nonexpansion states. However, studies have found nonexpansion states to be an appropriate control group for analysis of Medicaid expansion's effects on health coverage and access, despite economic changes as states recovered from the Great Recession; see, for example, Simon, Soni, and Cawley (2017).

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## Findings

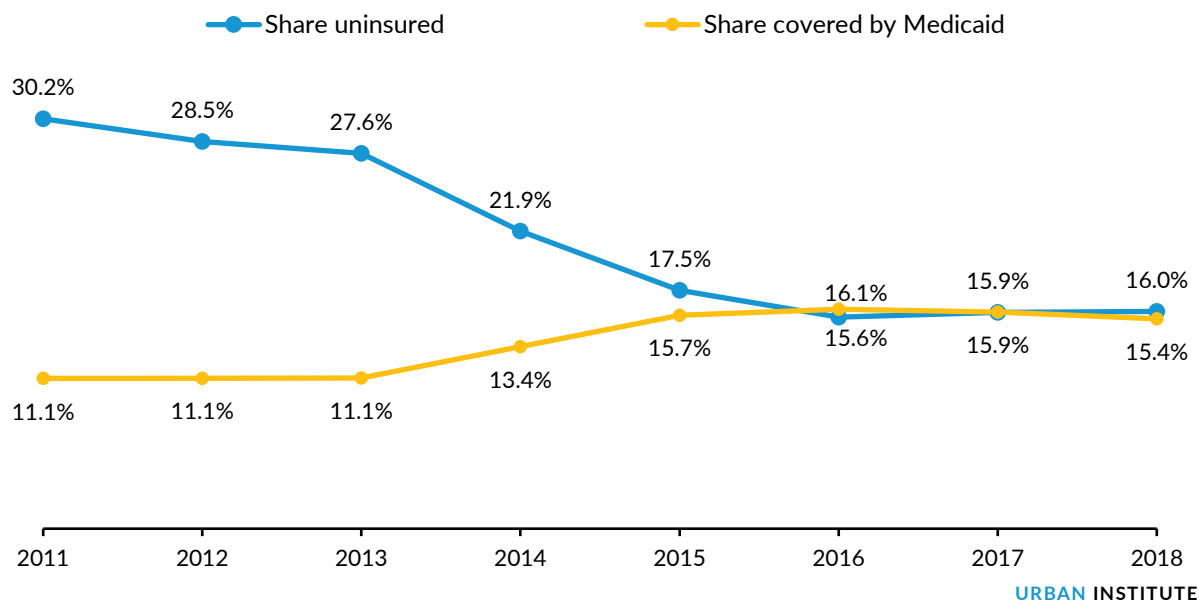
### How Have Uninsurance and Medicaid Coverage among Young Adults Changed under the ACA?

To understand trends in health insurance coverage for young adults between 2011 and 2018, we consider two outcomes: uninsurance rates and Medicaid coverage. Uninsurance rates could be affected by the full range of ACA coverage provisions, including Medicaid expansion, the availability of Marketplace subsidies, the dependent coverage provision, and the individual mandate. Medicaid coverage measures one type of health insurance and captures the pathway through which ACA Medicaid expansion could affect coverage and access among young adults.

Uninsurance among young adults ages 19 to 25 fell 14.2 percentage points between 2011 and 2018, from 30.2 percent to 16.0 percent (figure 1). The share of young adults covered by Medicaid increased 4.3 percentage points over that period, from 11.1 percent to 15.4 percent. Changes in both uninsurance and Medicaid coverage were concentrated between 2013 and 2016, when most major ACA coverage provisions were implemented, including Medicaid expansion and the establishment of

the Marketplaces. The uninsurance rate decreased by 5.7 percentage points between 2013 and 2014, by 4.4 percentage points between 2014 and 2015, and by 1.9 percentage points between 2015 and 2016. These large reductions in uninsurance through 2016 suggest the major ACA coverage provisions took several years to reach their full effect.

**FIGURE 1**  
**Trends in Uninsurance and Medicaid Coverage among Young Adults Ages 19 to 25, 2011–18**



**Source:** Authors' analysis of 2011–18 American Community Survey data.

**Notes:** Analysis excludes five states that extended Medicaid eligibility to nondisabled adults before Affordable Care Act enactment (DC, DE, MA, NY, VT) and excludes seven states that expanded Medicaid after January 1, 2014 (AK, IN, LA, MI, MT, NH, PA).

Considering trends in uninsurance among young adults by Medicaid expansion status, we find uninsurance declined in both expansion and nonexpansion states (figure 2).

## UNINSURANCE

Consistent with our assessment of national trends, declines in uninsurance rates for expansion and nonexpansion states were greatest beginning in 2014, when the core ACA coverage provisions were implemented. Still, the average decline in uninsurance rates was greater in expansion states.

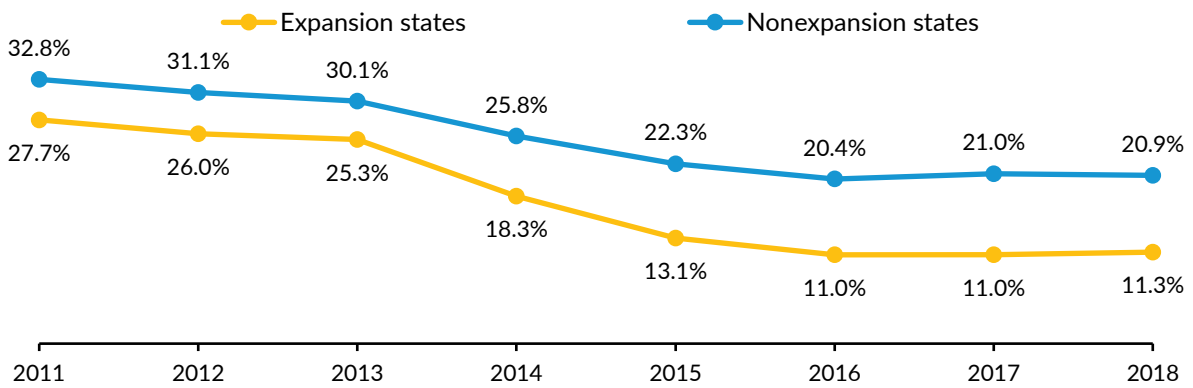
Uninsurance rates among young adults ages 19 to 25 declined by 16.4 percentage points in expansion states, from 27.7 percent in 2011 to 11.3 percent in 2018, and by 11.9 percentage points in nonexpansion states, from 32.8 percent in 2011 to 20.9 percent in 2018.

## MEDICAID COVERAGE

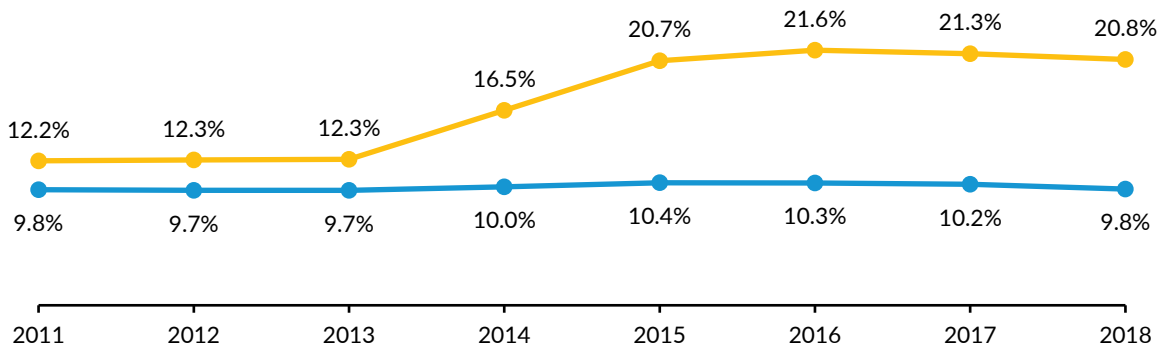
Young adults in expansion states experienced large gains in Medicaid coverage beginning in 2014, which more than explains the difference in the change in uninsurance rate between expansion and nonexpansion states. Medicaid coverage among young adults ages 19 to 25 in expansion states increased by 8.6 percentage points, from 12.2 percent in 2011 to 20.8 percent in 2018, with the greatest gains concentrated between 2013 and 2015. Medicaid coverage remained unchanged at 9.8 percent in nonexpansion states during the same period. Thus, though declines in young adults' uninsurance rates were prevalent in both expansion and nonexpansion states during this period, the rise in Medicaid coverage was unique to expansion states.

**FIGURE 2**  
**Trends in Uninsurance and Medicaid Coverage among Young Adults Ages 19 to 25, by Medicaid Expansion Status, 2011–18**

*Share of young adults uninsured*



*Share with Medicaid coverage*



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**Source:** Authors' analysis of 2011–18 American Community Survey data.

**Notes:** Analysis excludes five states that extended Medicaid eligibility to nondisabled adults before ACA enactment (DC, DE, MA, NY, VT) and excludes seven states that expanded Medicaid after January 1, 2014 (AK, IN, LA, MI, MT, NH, PA). States that

expanded Medicaid by January 1, 2014, are classified as expansion states; states that had not expanded Medicaid by the end of 2018 are classified as nonexpansion states.

## What Was the Impact of ACA Medicaid Expansion on Uninsurance and Medicaid Coverage among Young Adults?

We next directly assess the impact of Medicaid expansion on young adults' uninsurance and Medicaid coverage using a difference-in-differences model that assesses the change in uninsurance or Medicaid coverage in expansion states relative to nonexpansion states, after accounting for other ACA provisions' contributions to these outcomes.

### UNINSURANCE

Between 2011–13 and 2015–18, uninsurance rates fell at a faster pace in expansion states (a 14.7 percentage-point decline) than in nonexpansion states (10.1 percentage-point decline). We find the ACA Medicaid expansion is associated with a 3.6 percentage-point reduction in uninsurance among young adults ages 19 to 25, a 13.7 percent decline relative to the 2011–2013 expansion state average (table 1). We next consider impacts for subgroups of young adults.

- **Race/ethnicity.** We observe a large reduction in uninsurance for Hispanic young adults (6.0 percentage points), who had the highest pre-ACA uninsurance rates, compared with declines in uninsurance of 3.7 percentage points for non-Hispanic Black young adults and 2.5 percentage points for non-Hispanic white young adults. Before the ACA, Hispanic young adults had the highest uninsurance rates, and thus Medicaid expansion helped narrow differences in coverage by race/ethnicity among young adults.
- **Education.** Among young adults ages 22 to 25, we find significant declines in uninsurance rates for those without a college degree (4.9 percentage points) and a smaller and insignificant decline for those with a college degree or more education (0.7 percentage points).
- **Income.** We find the largest decline in uninsurance for young adults in low-income households (below 200 percent of FPL), who are more likely to be eligible for Medicaid expansion than those with higher incomes. Young adults in low-income households experienced a 7.5 percentage-point decline in uninsurance, a 20.1 percent decline relative to the 2011–2012 expansion state average. Young adults in higher-income households experienced a smaller and insignificant decline in uninsurance of 1.9 percentage points.

- **Other Characteristics.** We find similar effects for women (3.3 percentage points) and men (3.9 percentage points), for young adults ages 19 to 21 (3.9 percentage points) and ages 22 to 25 (3.4 percentage points), and for parents (4.3 percentage points) and childless adults (3.7 percentage points).

**TABLE 1**

**Changes in Uninsurance among Young Adults Ages 19 to 25 between 2011–13 and 2015–18, by Medicaid Expansion Status and Subgroup**

	Expansion States			Nonexpansion States			Adjusted DD	Sample size
	2011 -13	2015 -18	Difference	2011 -13	2015 -18	Difference		
<b>Uninsurance</b>								
<b>Full sample</b>	0.263	0.116	-0.147	0.313	0.211	-0.101	-0.036*	1,483,760
<b>Sex</b>								
Women	0.228	0.095	-0.134	0.281	0.189	-0.091	-0.033*	719,869
Men	0.297	0.137	-0.160	0.344	0.232	-0.111	-0.039*	763,891
<b>Race/ethnicity</b>								
Non-Hispanic White	0.180	0.075	-0.105	0.217	0.139	-0.078	-0.025*	839,756
Non-Hispanic Black	0.299	0.136	-0.163	0.374	0.249	-0.125	-0.037*	180,165
Hispanic	0.430	0.191	-0.240	0.531	0.372	-0.159	-0.060*	307,682
<b>Age</b>								
19–21	0.249	0.108	-0.141	0.300	0.206	-0.093	-0.039*	674,386
22–25	0.274	0.122	-0.152	0.324	0.215	-0.108	-0.034*	809,374
<b>Educational attainment (ages 22–25)</b>								
Less than a college degree	0.328	0.149	-0.178	0.378	0.259	-0.119	-0.049*	605,894
College degree or more	0.105	0.047	-0.058	0.113	0.071	-0.043	-0.007	203,480
<b>Parental status</b>								
Parents	0.280	0.126	-0.154	0.373	0.267	-0.105	-0.043*	173,744
Childless adults	0.261	0.115	-0.146	0.302	0.204	-0.098	-0.037*	1,310,016
<b>Income</b>								
< 200% of FPL	0.373	0.160	-0.213	0.424	0.299	-0.125	-0.075*	551,954
≥ 200% of FPL	0.187	0.089	-0.098	0.220	0.149	-0.071	-0.019	716,224

**Source:** Authors' analysis of 2011–13 and 2015–18 American Community Survey data.

**Notes:** DD = difference-in-differences. Analysis excludes five states that extended Medicaid eligibility to nondisabled adults before Affordable Care Act enactment (DC, DE, MA, NY, VT) and excludes seven states that expanded Medicaid after January 1, 2014 (AK, IN, LA, MI, MT, NH, PA). States that expanded Medicaid by January 1, 2014, are classified as expansion states; states that had not expanded Medicaid by the end of 2018 are classified as nonexpansion states. Adjusted difference-in-differences models include indicators for individual state of residence, survey year, sex, race/ethnicity, age, education (less than a high school diploma, a high school diploma only, greater than a high school diploma), parental status, marital status, and further control for state unemployment rates. Sample size is for adjusted model. Models use survey weights, and standard errors are clustered at the state level.

\* indicates the difference from the adjusted model is statistically significant at the  $p < .05$  level.



## MEDICAID COVERAGE

We also estimate the differences in Medicaid coverage by state expansion status and the impact of Medicaid expansion on young adult Medicaid coverage, finding that the Medicaid expansion was associated with a 7.6 percentage-point increase in Medicaid coverage among young adults (table A.1). Paralleling the patterns we found for changes in uninsurance, we observe large increases in Medicaid coverage for Hispanic and non-Hispanic Black young adults and smaller gains for non-Hispanic white young adults following Medicaid expansion. Gains in Medicaid coverage were again greater for young adults ages 22 to 25 without a college degree and were largest for young adults in low-income households (below 200 percent of FPL) more likely eligible for Medicaid expansion. For these low-income adults, Medicaid expansion was associated with a 12.6 percentage-point increase in Medicaid coverage, a 59.7 percent increase relative to the 2011–13 expansion state average. These gains in Medicaid coverage highlight that Medicaid coverage reduced uninsurance among young adults following ACA Medicaid expansion.

### **What Was the Impact of ACA Medicaid Expansion on Health Care Access and Use among Young Adults?**

By increasing rates of health insurance coverage among young adults, the ACA Medicaid expansion may have improved young adults' rates of health care access and use. We describe these patterns before and after Medicaid expansion, finding improvements in the available measures in both expansion states and nonexpansion states (table 2). The likelihood of receiving a routine checkup increased by 5.3 percentage points in expansion states (a 10 percent increase relative to 2011–13) and by 3.5 percentage points in nonexpansion states (a 6 percent increase). The likelihood of delaying needed care because of cost declined by 5.6 and 4.7 percentage points in expansion and nonexpansion states, respectively. The likelihood of having a personal doctor significantly increased by 2.1 percentage points in expansion states but did not change in nonexpansion states. We observe similar positive increases in the likelihood of receiving a flu shot or nasal spray in the past year in both expansion (2.7 percentage points) and nonexpansion states (2.2 percentage points).

We next directly assess the impact of Medicaid expansion on young adults' health care access and use using a difference-in-differences model that assesses the change in uninsurance or Medicaid coverage in expansion states relative to nonexpansion states, after accounting for other ACA provisions' contributions to these outcomes. Each of these impact estimates is in the direction suggesting Medicaid expansion improved access and use among young adults. Moreover, these estimated effect sizes are meaningful in magnitude, ranging from a 2.6 percent increase relative to the

2011–13 expansion state baseline for the likelihood of receiving a flu shot to a 4.6 percent decrease in the likelihood of delaying needed care because of cost. However, none of these estimates are statistically significant at conventional levels.

**TABLE 2**

**Changes in Health Care Access and Use among young Adults Ages 19 to 25 between 2011–13 and 2015–18, by Medicaid Expansion Status**

	Expansion States			Nonexpansion States			Adjusted DD	Sample Size
	2011 -13	2015 -18	Difference	2011 -13	2015 -18	Difference		
Received routine checkup in past 12 months	0.538	0.591	0.053	0.543	0.578	0.035	0.020	133,796
Delayed needed care because of cost in past 12 months	0.196	0.140	-0.056	0.231	0.185	-0.047	-0.009	136,750
Has a personal doctor	0.578	0.600	0.021	0.523	0.524	0.001	0.021	136,067
Received a flu shot/nasal spray in past 12 months	0.235	0.261	0.027	0.242	0.263	0.022	0.006	124,981

**Source:** Authors' analysis of 2011–2013 and 2015–2018 Behavioral Risk Factor Surveillance System data.

**Notes:** DD = difference-in-differences. Analysis excludes five states that extended Medicaid eligibility to nondisabled adults before Affordable Care Act enactment (DC, DE, MA, NY, VT) and excludes seven states that expanded Medicaid after January 1, 2014 (AK, IN, LA, MI, MT, NH, PA). States that expanded Medicaid by January 1, 2014, are classified as expansion states; states that had not expanded Medicaid by the end of 2018 are classified as nonexpansion states. Adjusted difference-in-differences models include indicators for state of residence, survey year, sex, race/ethnicity, age, education (less than a high school diploma, a high school diploma only, greater than a high school diploma), parental status (parent, childless adult, missing parental status), marital status, and further control for state unemployment rates. Sample size is for adjusted model. Models use survey weights, and standard errors are clustered at the state level.

\* indicates the difference from the adjusted model is statistically significant at the  $p < .05$  level.

**DIFFERENCES IN EFFECTS OF ACA MEDICAID EXPANSION BY EDUCATION AND INCOME**

Examining access to care effects among all young adults risks diluting the true effect of Medicaid expansion on those gaining insurance coverage, considering that many young adults are ineligible for Medicaid and may be unaffected by the program. We examine estimates of the impact of Medicaid expansion on young adults' access to care separately for those without and with a college degree (among those ages 22 to 25) and those residing in low- versus high-income households (figure 3). We examine these subgroups because we have clear predictions about how ACA Medicaid expansion will differently affect these groups, based on eligibility rules and because we have already observed major differences in the impact of Medicaid expansion on coverage for young adults who are socioeconomically disadvantaged.

**Educational attainment.** In the first subgroup analysis, we assess effects of Medicaid expansion on access to care among young adults ages 22 to 25 by whether they have attained a college degree. We expect those with a college degree are likely to reside in higher-income households and are therefore less likely to be eligible for Medicaid, irrespective of state expansion status.

Among young adults ages 22 to 25 without a college degree, we find Medicaid expansion is associated with a significantly increased likelihood of receiving a checkup in the past year (4.1 percentage points) and having a personal doctor (3.5 percentage points; figure 3). However, for this group of young people, we do not find a statistically significant relationship between Medicaid expansion and the likelihoods of delaying needed care because of cost or receiving a flu shot in the past year. We estimate small and insignificant effects of Medicaid expansion on all measures of access to care among young adults ages 22 to 25 with a college degree.

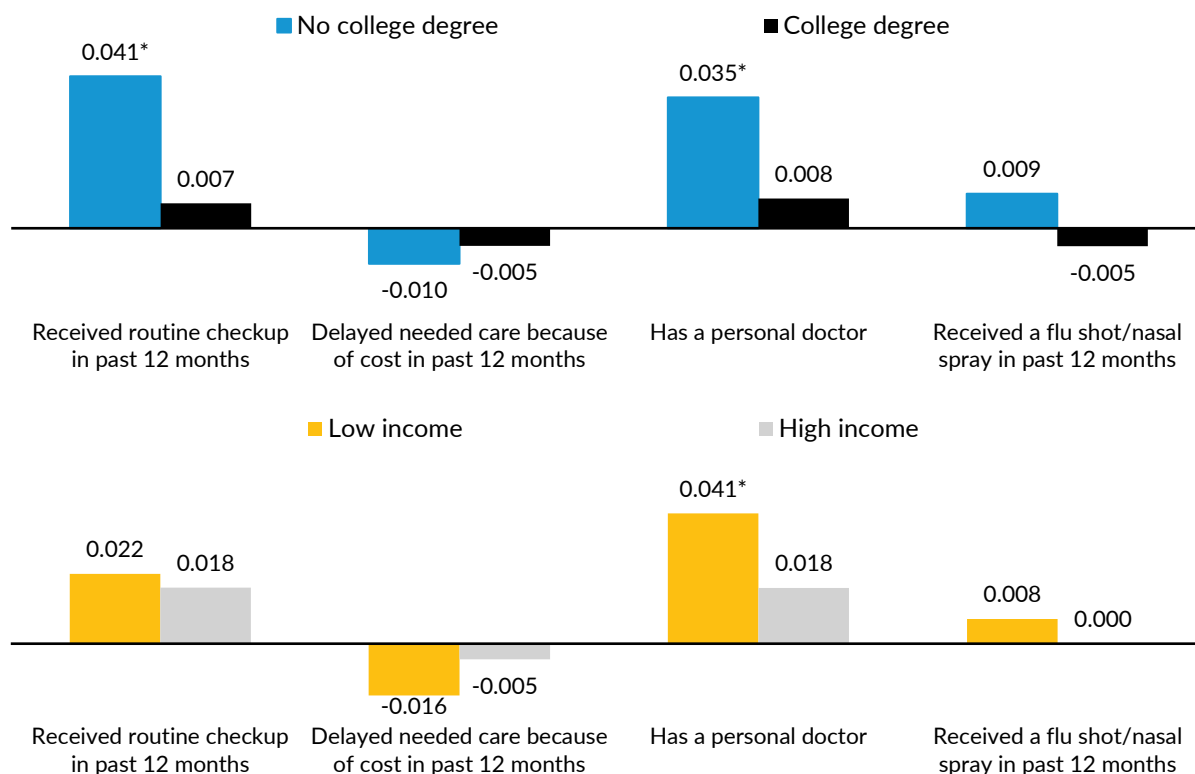
**Income.** In our second subgroup analysis, we compare the effects of Medicaid expansion by young adults living in low- or high-income households. Though income is more directly related to Medicaid eligibility, household income in the BRFSS likely has major measurement error. We thus use a broad income definition rather than restrict our assessment to groups directly eligible or ineligible for Medicaid. We expect a larger share of respondents in the low-income category would be eligible for Medicaid than in the high-income category and therefore expect effects of Medicaid expansion to be larger in this group than the high-income group.

Among young adults in low-income households, we find Medicaid expansion is associated with an increased likelihood of having a routine checkup in the past year (2.2 percentage points) and a personal doctor (4.1 percentage points; figure 3). However, only the effect on having a personal doctor is statistically significant. We find relatively no change in the likelihood of having a personal doctor among young adults residing in higher-income households. The estimated impact of Medicaid expansion on routine checkups in the past year was qualitatively similar among young adults with lower and higher incomes. Among lower-income young adults, we find Medicaid expansion is associated with a sizeable, though statistically insignificant, decrease in the likelihood of delaying needed care because of cost in the past year (1.6 percentage points). This decline is smaller among higher-income young adults (0.5 percentage points).

Altogether, figure 3 indicates stronger changes in health care access and use among the groups of young adults who were predicted to be more likely eligible for Medicaid expansion and experienced larger coverage gains under the Medicaid expansion relative to the full sample.

FIGURE 3

Impact of Medicaid Expansion on Health Care Access and Use among Young Adults, by Whether Young Adults Have a College Degree and High or Low Income, 2011–13 and 2015–18



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Source: Authors' analysis of 2011–13 and 2015–18 Behavioral Risk Factor Surveillance System data.

Notes: Estimates reflect intention-to-treat effect of Medicaid expansion on outcome measures from an adjusted difference-in-differences model using indicators for state of residence, survey year, sex, race/ethnicity, age, parental status (parent, childless adult, missing parental status), and marital status. Sample by college degree attainment restricted to young adults ages 22 to 25. Low- versus high-income household designation based on median value of household income as a ratio of the number of children in the household plus the respondent. Analysis excludes five states that extended Medicaid eligibility to nondisabled adults before ACA enactment (DC, DE, MA, NY, VT) and excludes seven states that expanded Medicaid after January 1, 2014 (AK, IN, LA, MI, MT, NH, PA). States that expanded Medicaid by January 1, 2014, are classified as expansion states; states that had not expanded Medicaid by the end of 2018 are classified as nonexpansion states. Models use survey weights, and standard errors are clustered at the state level.

\* indicates the difference from the adjusted model is statistically significant at the  $p < .05$  level.

DIFFERENCES IN EFFECTS OF ACA MEDICAID EXPANSION BY OTHER CHARACTERISTICS

Finally, we estimated the impact of Medicaid expansion on health care access and use for subgroups of young adults, finding expansion was associated with significant reductions in delaying needed care because of cost for young adult men, non-Hispanic Black young adults, and childless young adults, as well as a significant increase in having a routine checkup for non-Hispanic white young adults (table A.2). We also find Medicaid expansion was associated with significant improvements in the likelihood

of having a personal doctor among young adult men, non-Hispanic Black young adults, Hispanic young adults, young adults without a college degree, and those in the low-income category.

## Conclusions and Implications for Policy

In 2011, three years before implementation of the ACA's major coverage provisions, more than one-quarter of young adults ages 19 to 25 in the United States were uninsured. Seven years later, in 2018, uninsurance rates had declined to under 15 percent for this age group. We find Medicaid expansion, specifically, was associated with a 13.7 percent reduction in uninsurance rates relative to the pre-ACA average in expansion states. Coverage gains under the ACA Medicaid expansion were largest for young adults in low-income households, with notable gains for Hispanic young adults, non-Hispanic Black young adults, and young adults ages 22 to 25 without a college degree.

We also find improvements in health care access and use measures in both expansion and nonexpansion states, with evidence that Medicaid expansion contributed to statistically significant increases in receiving routine checkups and having a personal doctor among young adults ages 22 to 25 who do not have a college degree. Groups of young adults who experienced large coverage gains under Medicaid expansion generally exhibited large but statistically insignificant improvements on select measures of health care access and use. Among non-Hispanic Black young adults, Medicaid expansion was associated with a large 5.0 percentage-point decline in the likelihood of delaying needed care because of cost in the past year, a 19 percent decline relative to the baseline. Following Medicaid expansion, non-Hispanic Black and Hispanic young adults in expansion states were more likely to have a personal doctor than those in nonexpansion states.

These findings suggest expanding Medicaid in additional states could further improve coverage and access to care among young adults, particularly those who are socioeconomically disadvantaged (box 2); our evidence implies Medicaid expansion likely improved health care access and use for young adults with lower incomes or without a college degree in the seven states omitted from this analysis that implemented expansion between 2016 and 2020. Further, the COVID-19 pandemic and resulting loss of employer-sponsored insurance have increased the likely benefit of implementing Medicaid expansion in states yet to expand coverage under the ACA (Buettgens 2021).

Opportunities to increase coverage and access to care for young adults remain in Medicaid expansion states as well. In 2016, the vast majority of uninsured young adults ages 19 to 34 were likely eligible for either Medicaid coverage or Marketplace subsidies, with barriers to enrollment

ranging from lack of knowledge of these coverage options to concerns about affordability (Collins et al. 2016). Policy solutions such as increased marketing, targeted outreach to young adults, one-on-one enrollment assistance, and improved enrollment systems could increase take-up of coverage (Artiga, Rudowitz, and Tolbert 2016). Assistance from ACA navigators has been found to be a strong determinant of enrollment in coverage (Sommers et al. 2015).

Despite improvements in young adult health coverage and access following the implementation of the major ACA coverage provisions, 20.9 percent of young adults in nonexpansion states and 11.3 percent of young adults in expansion states were uninsured in 2018, indicating more can be done to reduce uninsurance for this group. Further, we find many young adults were still going without preventive care in 2018; sixty percent or less of young adults received a checkup in the previous year or had a personal doctor, only slightly more than one-quarter received a flu vaccine, and between 14 and 19 percent reported delaying needed care because of cost in the past year.

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## BOX 2

### Policy Implications

- Adopting ACA Medicaid expansion in the 12 remaining nonexpansion states could reduce uninsurance and increase access to care among young adults, particularly those in low-income households or without a college degree.
- Investment in outreach, such as increased marketing, targeted messaging to young adults, one-on-one enrollment assistance, and improved enrollment systems, could reduce uninsurance among young adults by enrolling those who are uninsured but eligible for Medicaid into the program.
- For young adults not eligible for Medicaid coverage, expanding the availability of Marketplace premiums to those with incomes below the poverty level in nonexpansion states, increasing the value of Marketplace premium subsidies, and increasing cost-sharing reductions could reduce uninsurance and improve health care access and use by increasing affordability of Marketplace coverage.
- Increased coverage alone is unlikely to ensure all young adults can afford to access and use the health care they need. More research is needed to understand barriers to receipt of recommended preventive care among young adults with health insurance.

The effects of Medicaid expansion on young adults' health insurance coverage and health care access provide evidence of the initial pathways through which Medicaid expansions could improve young adults' overall health and trajectories of health throughout adulthood. Beyond coverage and access to preventive care, Medicaid expansion may affect young adults' health care use in ways not examined in this report. For example, among nonelderly adults, ACA Medicaid expansion has been found to increase access to treatment for substance use disorder, for which young adulthood is a critical treatment period (Maclean and Saloner 2019; Substance Abuse and Mental Health Services Administration and Office of the Surgeon General 2016; Wen et al. 2017). Medicaid expansion has also decreased churning between insurance and uninsurance surrounding pregnancy, increased receipt of preconception health counseling, increased preconception folic acid intake, and increased postpartum contraceptive use—important improvements in coverage and use of recommended health services for people who give birth, including thousands of young adults each year (Daw et al. 2017; Myerson, Crawford, and Wherry 2020). Thus, ensuring young adults have health insurance coverage and access to affordable care is a critical first step for their long-term health.

# Appendix A. Supplementary Tables

TABLE A.1

Changes in Medicaid Coverage among Young Adults Ages 19 to 25 between 2011–2013 and 2015–2018, by Medicaid Expansion Status and Subgroup

Sample	Expansion States			Nonexpansion States			Adjusted DD	Sample Size
	2011 -13	2015 -18	Difference	2011 -13	2015 -18	Difference		
<b>Medicaid</b>								
full sample	0.123	0.211	0.088	0.098	0.102	0.004	0.076*	1,483,760
<b>Sex</b>								
Women	0.160	0.243	0.083	0.130	0.129	-0.001	0.076*	719,869
Men	0.088	0.181	0.093	0.067	0.076	0.010	0.077*	763,891
<b>Race/ethnicity</b>								
Non-Hispanic White	0.090	0.150	0.060	0.078	0.081	0.004	0.053*	839,756
Non-Hispanic Black	0.235	0.324	0.089	0.173	0.171	-0.002	0.089*	180,165
Hispanic	0.155	0.293	0.138	0.086	0.097	0.011	0.112*	307,682
<b>Age</b>								
19–21	0.127	0.224	0.097	0.100	0.108	0.008	0.080*	674,386
22–25	0.120	0.202	0.082	0.096	0.098	0.002	0.073*	809,374
<b>Educational attainment (ages 22–25)</b>								
Less than a college degree	0.151	0.252	0.101	0.116	0.120	0.004	0.088*	605,894
College degree or more	0.020	0.063	0.043	0.017	0.022	0.005	0.034*	203,480
<b>Parental status</b>								
Parents	0.371	0.471	0.101	0.256	0.265	0.009	0.089*	173,744
Childless Adults	0.086	0.182	0.096	0.068	0.079	0.010	0.077*	1,310,016
<b>Income</b>								
< 200% of FPL	0.211	0.359	0.149	0.155	0.168	0.013	0.126*	551,954
≥ 200% of FPL	0.056	0.125	0.069	0.047	0.057	0.010	0.052*	716,224

Source: Authors' analysis of 2011–2013 and 2015–2018 American Community Survey data.

Notes: Analysis excludes five states that extended Medicaid eligibility to nondisabled adults before Affordable Care Act enactment (DC, DE, MA, NY, VT) and excludes seven states that expanded Medicaid after January 1, 2014 (AK, IN, LA, MI, MT, NH, PA). States that expanded Medicaid by January 1, 2014, are classified as expansion states; states that had not expanded Medicaid by the end of 2018 are classified as nonexpansion states. Sample restricted to adults ages 19 to 25 and years 2011–2013 and 2015–2018. Adjusted difference-in-differences models include indicators for state of residence, survey year, sex, race/ethnicity, age, education (less than a high school diploma, a high school diploma only, greater than a high school diploma,) parental status, marital status, and further control for state unemployment rates. Sample size is for adjusted model. Models use survey weights and standard errors are clustered at the state level. \* indicates the difference from the adjusted model is statistically significant at the  $p < .05$  level.



TABLE A.2

Changes in Health Care Access and Use among Young Adults Ages 19 to 25 between 2011–2013 and 2015–2018, by Medicaid Expansion Status and Subgroup

Sample	Expansion States			Nonexpansion States			Adjusted DD	Sample Size
	2011 -13	2015 -18	Difference	2011 -13	2015 -18	Difference		
<b>Received routine checkup in past 12 months</b>								
<i>Full sample</i>	0.538	0.591	0.053	0.543	0.578	0.035	0.020	133,796
<i>Sex</i>								
Women	0.604	0.649	0.045	0.614	0.641	0.027	0.013	66,036
Men	0.476	0.537	0.061	0.477	0.519	0.042	0.029	67,760
<i>Race/ethnicity</i>								
Non-Hispanic								
White	0.522	0.584	0.062	0.523	0.558	0.035	0.034*	84,666
Non-Hispanic								
Black	0.660	0.691	0.031	0.661	0.684	0.023	0.010	12,523
Hispanic	0.527	0.567	0.040	0.501	0.552	0.051	-0.017	21,234
<i>Age</i>								
19–21	0.569	0.614	0.045	0.564	0.596	0.032	0.008	52,837
22–25	0.512	0.572	0.060	0.527	0.565	0.038	0.031*	80,959
<i>Educational attainment (ages 22–25)</i>								
Less than a college degree	0.489	0.567	0.078	0.512	0.551	0.039	0.041*	54,328
College degree or more	0.580	0.588	0.008	0.583	0.608	0.025	0.007	26,631
<i>Parental status</i>								
Parents	0.567	0.598	0.031	0.544	0.589	0.045	0.016	11,712
Childless adults	0.534	0.589	0.055	0.535	0.578	0.043	0.019	98,177
<i>Household income</i>								
Low income	0.506	0.574	0.068	0.514	0.558	0.044	0.022	54,768
High income	0.567	0.596	0.029	0.586	0.602	0.015	0.018	50,545
<b>Delayed needed care because of cost in past 12 months</b>								
<i>Full sample</i>	0.196	0.140	-0.056	0.231	0.185	-0.047	-0.009	136,750
<i>Sex</i>								
Women	0.216	0.162	-0.054	0.278	0.222	-0.056	0.003	67,375
Men	0.177	0.120	-0.057	0.188	0.149	-0.039	-0.021*	69,375
<i>Race/ethnicity</i>								
Non-Hispanic								
White	0.171	0.123	-0.048	0.188	0.155	-0.033	-0.020	86,652
Non-Hispanic								
Black	0.263	0.157	-0.106	0.282	0.224	-0.058	-0.050*	12,764
Hispanic	0.240	0.179	-0.061	0.301	0.231	-0.071	0.025	21,651
<i>Age</i>								
19–21	0.159	0.118	-0.042	0.199	0.167	-0.032	-0.012	54,170
22–25	0.226	0.159	-0.067	0.256	0.198	-0.058	-0.006	82,580

Sample	Expansion States			Nonexpansion States			Adjusted DD	Sample Size
	2011 -13	2015 -18	Difference	2011 -13	2015 -18	Difference		
<i>Educational attainment (ages 22-25)</i>								
Less than a college degree	0.260	0.176	-0.083	0.291	0.221	-0.070	-0.010	55,544
College degree or more	0.126	0.106	-0.020	0.134	0.121	-0.013	-0.005	27,036
<i>Parental status</i>								
Parents	0.228	0.159	-0.069	0.332	0.237	-0.096	-0.004	11,991
Childless adults	0.182	0.137	-0.045	0.194	0.167	-0.028	-0.020*	100,296
<i>Household income</i>								
Low income	0.271	0.184	-0.086	0.313	0.242	-0.071	-0.016	55,724
High income	0.115	0.109	-0.005	0.126	0.125	-0.002	-0.005	51,283
<b>Has a personal doctor</b>								
Full sample	0.578	0.600	0.021	0.523	0.524	0.001	0.021	136,067
<i>Sex</i>								
Women	0.654	0.658	0.004	0.590	0.588	-0.002	0.005	67,196
Men	0.507	0.545	0.038	0.460	0.463	0.003	0.039*	68,871
<i>Race/ethnicity</i>								
Non-Hispanic White	0.634	0.648	0.013	0.579	0.588	0.009	0.010	86,212
Non-Hispanic Black	0.552	0.628	0.076	0.517	0.515	-0.002	0.084*	12,708
Hispanic	0.489	0.524	0.036	0.402	0.391	-0.011	0.042*	21,558
<i>Age</i>								
19-21	0.620	0.631	0.011	0.551	0.548	-0.003	0.015	53,721
22-25	0.544	0.575	0.031	0.501	0.506	0.005	0.027	82,346
<i>Educational attainment (ages 22-25)</i>								
Less than a college degree	0.514	0.559	0.046	0.477	0.483	0.006	0.035*	55,371
College degree or more	0.636	0.621	-0.015	0.591	0.580	-0.011	0.008	26,975
<i>Parental status</i>								
Parents	0.583	0.617	0.034	0.517	0.537	0.019	0.031*	11,981
Childless adults	0.580	0.602	0.022	0.520	0.530	0.010	0.016	99,758
<i>Household income</i>								
Low income	0.513	0.562	0.049	0.477	0.482	0.005	0.041*	55,546
High income	0.659	0.641	-0.018	0.615	0.581	-0.034	0.018	51,080
<b>Received a flu shot or nasal spray in past 12 months</b>								
Full sample	0.235	0.261	0.027	0.242	0.263	0.022	0.006	124,981
<i>Sex</i>								
Women	0.269	0.294	0.025	0.259	0.286	0.028	-0.004	61,663
Men	0.202	0.230	0.028	0.226	0.241	0.016	0.016	63,318
<i>Race/ethnicity</i>								

Sample	Expansion States			Nonexpansion States			Adjusted DD	Sample Size
	2011 -13	2015 -18	Difference	2011 -13	2015 -18	Difference		
Non-Hispanic White	0.242	0.277	0.035	0.258	0.279	0.021	0.015	80,442
Non-Hispanic Black	0.217	0.222	0.004	0.204	0.213	0.009	-0.005	11,212
Hispanic	0.214	0.230	0.015	0.230	0.249	0.019	0.006	19,164
Age								
19-21	0.241	0.267	0.026	0.238	0.264	0.025	0.007	49,349
22-25	0.229	0.256	0.028	0.244	0.263	0.018	0.006	75,632
Educational attainment (ages 22-25)								
Less than a college degree	0.217	0.237	0.020	0.233	0.241	0.009	0.009	50,396
College degree or more	0.263	0.311	0.048	0.283	0.332	0.049	-0.005	25,236
Parental status								
Parents	0.264	0.282	0.018	0.273	0.271	-0.002	0.002	11942
Childless adults	0.226	0.254	0.028	0.235	0.259	0.025	0.003	93571
Household income								
Low income	0.226	0.261	0.034	0.227	0.251	0.025	0.008	51,033
High income	0.249	0.266	0.017	0.270	0.289	0.019	0.000	47,917

**Source:** Authors' analysis of 2011-2013 and 2015-2018 Behavioral Risk Factor Surveillance System data.

**Notes:** Analysis excludes five states that extended Medicaid eligibility to nondisabled adults before ACA enactment (DC, DE, MA, NY, VT) and excludes seven states that expanded Medicaid after January 1, 2014 (AK, IN, LA, MI, MT, NH, PA). States that expanded Medicaid by January 1, 2014, are classified as expansion states; states that had not expanded Medicaid by the end of 2018 are classified as nonexpansion states. Sample restricted to adults ages 19 to 25 and years 2011-2013 and 2015-2018. Adjusted difference-in-differences models include indicators for state of residence, survey year, sex, race/ethnicity, age, education (less than a high school diploma, a high school diploma only, greater than a high school diploma,) parental status (parent, childless adult, missing parental status), marital status, and further control for state unemployment rates. White and Black are limited to individuals who do not report Hispanic ethnicity. Low (high) household income identified based on respondents having below (above) median value of household income as a ratio of number of children in the household plus respondent. Sample size is for adjusted model. Models use survey weights and standard errors are clustered at the state level. \* indicates the difference from the adjusted model is statistically significant at the  $p < .05$  level.

# Notes

- <sup>1</sup> US Census Bureau, “Another Look at Health Insurance Coverage Rates for Young Adults,” *Newsroom* (blog), September 6, 2018, [https://www.census.gov/newsroom/blogs/random-samplings/2018/09/another\\_look\\_at\\_heal.html](https://www.census.gov/newsroom/blogs/random-samplings/2018/09/another_look_at_heal.html).
- <sup>2</sup> Richard Bonnie and Martin Sepulveda, “Investing in the Health and Well-Being of Young Adults,” *Health Affairs Blog*, December 15, 2014, <https://www.healthaffairs.org/doi/10.1377/hblog20141215.043313/full/>.
- <sup>3</sup> Census Bureau, “Another Look at Health Insurance Coverage Rates.” [https://www.census.gov/newsroom/blogs/random-samplings/2018/09/another\\_look\\_at\\_heal.html](https://www.census.gov/newsroom/blogs/random-samplings/2018/09/another_look_at_heal.html)
- <sup>4</sup> “Status of State Action on the Medicaid Expansion Decision – Timeframe: February 4, 2021,” Henry J. Kaiser Family Foundation, accessed February 11, 2021, <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- <sup>5</sup> Federal rules require states to extend Medicaid eligibility to low-income parents traditionally eligible under Section 1931 of the Social Security Act, which typically includes those with incomes below half of the federal poverty level; see Joan Alker, “Which Parents Would Still Be Covered If Medicaid Expansion Goes Away?” Georgetown University Health Policy Institute, Center for Children and Families, June 14, 2017, <https://ccf.georgetown.edu/2017/06/14/what-parents-would-still-be-covered-if-medicaid-expansion-goes-away/>. Some states expanded Medicaid eligibility for parents before the ACA passed, with 18 states setting parental eligibility above the federal poverty level in 2011; see “Medicaid Income Eligibility Limits for Parents, 2002–2020,” Henry J. Kaiser Family Foundation, accessed February 9, 2021, <https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/>. Federal rules also require states to extend Medicaid eligibility for pregnant women with household incomes up to 138 percent of FPL, and most states set Medicaid income thresholds for pregnant women above this threshold (Haley et al. 2021). In contrast, there is no federal rule requiring states extend Medicaid eligibility to nondisabled childless adults, and only nine states covered this group in 2013; see “Medicaid Income Eligibility Limits for Other Nondisabled Adults, 2011–2020,” Henry J. Kaiser Family Foundation, accessed February 9, 2021, <https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-other-non-disabled-adults/?currentTimeframe=0&selectedDistributions=january-2011--january-2012--january-2013&sortModel=%7B%22colld%22:%22January%202013%22,%22sort%22:%22desc%22%7D>.
- <sup>6</sup> Steven Ruggles, Sarah Flood, Ronald Goeken, Josiah Grover, Erin Meyer, Jose Pacas, and Matthew Sobek, “IPUMS USA: Version 9.0” [dataset], <https://doi.org/10.18128/D010.V9.0>.
- <sup>7</sup> Coverage through the Indian Health Service is not considered comprehensive health insurance coverage. Young adults who report coverage through the Indian Health Service and no other source of coverage are considered uninsured.
- <sup>8</sup> By beginning our analysis in 2011 we avoid comparing estimates across years that changed sample design in the BRFSS.
- <sup>9</sup> For simplicity, the District of Columbia is considered a state for this analysis.
- <sup>10</sup> Delaware, the District of Columbia, Massachusetts, New York, and Vermont had generous Medicaid eligibility programs in place before the ACA.
- <sup>11</sup> Alaska, Indiana, Louisiana, Michigan, Montana, New Hampshire, and Pennsylvania expanded Medicaid after January 1, 2014.
- <sup>12</sup> The 19 nonexpansion states are Alabama, Florida, Georgia, Idaho, Kansas, Maine, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia,

Wisconsin, and Wyoming. Expansion states include 15 states that expanded Medicaid by January 1, 2014: Arizona, Arkansas, Colorado, Hawaii, Illinois, Iowa, Kentucky, Maryland, Nevada, New Mexico, North Dakota, Ohio, Oregon, Rhode Island, and West Virginia. Five states had at least partly expanded Medicaid under the ACA before January 1, 2014: California, Connecticut, Minnesota, New Jersey, and Washington. Idaho, Maine, Nebraska, Utah, and Virginia expanded Medicaid programs after 2018. Missouri and Oklahoma are expected to implement Medicaid expansion in 2021, but we classify them as nonexpansion states because expansion had not yet occurred during the study period, 2011–2018.

- <sup>13</sup> For example, the 2018 BRFSS had a 53 percent response rate for landline interviews and a 43 percent response rate for cell phone interviews (BRFSS 2019). By comparison, the 2018 ACS response rate, which includes a second mailing, telephone follow-up, or in-person follow-up, was 92 percent. See “American Community Survey: Response Rates,” US Census Bureau, accessed February 9, 2021, <https://www.census.gov/acs/www/methodology/sample-size-and-data-quality/response-rates/>.
- <sup>14</sup> Throughout this report, we describe young adults using the language in our data sources. However, we recognize the limitations of these terms, especially in surveys that ask respondents to self-identify, and remain committed to using respectful, inclusive language. Our demographic and economic indicators of interest are defined as follows. Sex is measured as male or female; race/ethnicity is measured as four mutually exclusive categories (Hispanic, non-Hispanic Black, non-Hispanic other, and non-Hispanic white); educational attainment is measured as three mutually exclusive categories (less than high school, high school, and some college or more); parental status is measured as any children in the household or no children in the household; marital status is measured as married or unmarried; and we include age indicators for each age between 19 and 25.
- <sup>15</sup> Medicaid eligibility under the ACA depends on household income and could incentivize households to reduce earnings below 138 percent of FPL to gain access to Medicaid. This could create a composition problem and could make households with incomes below 138 percent of FPL noncomparable before and after Medicaid expansion in expansion states. To avoid this limitation, we opted to specify our low-income sample at a slightly higher income threshold. Further, estimation of household income for young adults is particularly complex, as many young adults reside in group quarters, such as college dormitories or with roommates outside of their households. We expect high measurement error in calculating household income and therefore use 200 percent of FPL as a cutoff to approximate young adults who may be more likely to have low incomes and qualify for Medicaid.
- <sup>16</sup> BRFSS measures of household income are categorical and, before 2014, cell phone respondents did not identify the number of adults in the household. Thus, it is difficult to construct an accurate measurement of income as a percentage of FPL. Instead, we impute household income using the midpoint of BRFSS categorical values and divide this value by the number of children plus the adult respondent. We then identify a low- (high-) income sample as all respondents with a value below (above) the median value of this measure.

# References

- Antwi, Yaa Akosa, Asako S. Moriya, and Kosali Simon. 2013. "Effects of Federal Policy to Insure Young Adults: Evidence from the 2010 Affordable Care Act's Dependent-Coverage Mandate." *American Economic Journal: Economic Policy* 5 (4): 1–28. <https://doi.org/10.1257/pol.5.4.1>.
- Artiga, Samantha, Robin Rudowitz, and Jennifer Tolbert. 2016. "Outreach and Enrollment Strategies for Reaching the Medicaid Eligible but Uninsured Population." Menlo Park, CA: Henry J. Kaiser Family Foundation.
- Barbaresco, Silvia, Charles J. Courtemanche, and Yanling Qi. 2015. "Impacts of the Affordable Care Act Dependent Coverage Provision on Health-Related Outcomes of Young Adults." *Journal of Health Economics* 40: 54–68.
- Boudreaux, Michel H., Kathleen Thiede 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.
- BRFSS (Behavioral Risk Factor Surveillance System). 2019. *Behavioral Risk Factor Surveillance System: 2018 Summary Data Quality Report—July 17, 2019*. Atlanta: Centers for Disease Control and Prevention.
- Buettgens, Matthew. 2021. "Medicaid Would Have a Larger Impact Than Ever during the COVID-19 Pandemic." Washington, DC: Urban Institute.
- Busch, Susan H., Ezra Golberstein, and Ellen Meara. 2014. "ACA Dependent Coverage Provision Reduced High Out-of-Pocket Health Care Spending for Young Adults." *Health Affairs* 33 (8): 1361–66. <https://doi.org/10.1377/hlthaff.2014.0155>.
- Cantor, Joel C., Alan C. Monheit, Derek DeLia, and Kristen Lloyd. 2012. "Early Impact of the Affordable Care Act on Health Insurance Coverage of Young Adults." *Health Services Research* 47 (5): 1773–90. <https://doi.org/10.1111/j.1475-6773.2012.01458.x>.
- Cohen, Robin A., and Barbara Bloom. 2010. "Access to and Utilization of Medical Care for Young Adults Ages 20–29 Years, United States, 2008." Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics.
- Collins, Sara R., Munira Z. Gunja, Michelle M. Doty, and Sophie Beutel. 2016. "Who Are the Remaining Uninsured and Why Haven't They Signed Up for Coverage?" New York: Commonwealth Fund.
- Courtemanche, Charles, James Marton, Benjamin Ukert, Aaron Yelowitz, and Daniela Zapata. 2017. "Early Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States." *Journal of Policy Analysis and Management* 36 (1): 178–210. <https://doi.org/10.1002/pam.21961>.
- Daw, Jamie R., and Benjamin D. Sommers. 2019. "The Affordable Care Act and Access to Care for Reproductive-Aged and Pregnant Women in the United States, 2010–2016." *American Journal of Public Health*, February, e1–7. <https://doi.org/10.2105/AJPH.2018.304928>.
- Daw, Jamie R., Tyler N. A. Winkelmann, Vanessa K. Dalton, Katy B. Kozhimannil, and Lindsay K. Admon. 2020. "Medicaid Expansion Improved Perinatal Insurance Continuity for Low-Income Women: Study Examines the Impact of State Medicaid Expansions on Continuity of Insurance Coverage for Low-Income Women across Three Time Points: Preconception, Delivery, and Postpartum." *Health Affairs* 39 (9): 1531–39.
- Griffith, Kevin N. 2020. "Changes in Insurance Coverage and Access to Care for Young Adults in 2017." *Journal of Adolescent Health* 66 (1): 86–91. <https://doi.org/10.1016/j.jadohealth.2019.05.020>.
- Guth, Madeline, Rachel Garfield, and Robin Rudowitz. 2020. "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review." San Francisco: Henry J. Kaiser Family Foundation.

- Haley, Jennifer M., Emily M. Johnston, Ian Hill, Genevieve M. Kenney, and Tyler W. Thomas. 2021. *The Public Health Insurance Landscape for Pregnant and Postpartum Women*. Washington, DC: Urban Institute.
- Holahan, John, and Genevieve M Kenney. 2008. "Health Insurance Coverage of Young Adults: Issues and Broader Considerations." Washington, DC: Urban Institute.
- Johnston, Emily M., Andrea E. Strahan, Peter Joski, Anne L. Dunlop, and E. Kathleen Adams. 2018. "Impacts of the Affordable Care Act's Medicaid Expansion on Women of Reproductive Age: Differences by Parental Status and State Policies." *Women's Health Issues* 28 (2): 122–29. <https://doi.org/10.1016/j.whi.2017.11.005>.
- Kaestner, Robert, Bowen Garrett, Jiajia Chen, Anuj Gangopadhyaya, and Caitlyn Fleming. 2017. "Effects of ACA Medicaid Expansions on Health Insurance Coverage and Labor Supply." *Journal of Policy Analysis and Management* 36 (3): 608–42. <https://doi.org/10.1002/pam.21993>.
- Kamal, Rabah, Cynthia Cox, Rachel Fehr, Marco Ramirez, Katherine Horstman, and Larry Levitt. 2018. "How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans Are Affecting 2019 Premiums." San Francisco: Henry J. Kaiser Family Foundation.
- Lau, Josephine S., Sally H. Adams, Charles E. Irwin, Jr., and Elizabeth M. Ozer. 2013. "Receipt of Preventive Health Services in Young Adults." *Journal of Adolescent Health* 52 (1): 42–49.
- Lau, Josephine S., Sally H. Adams, M. Jane Park, W. John Boscardin, and Charles E. Irwin. 2014. "Improvement in Preventive Care of Young Adults after the Affordable Care Act: The Affordable Care Act Is Helping." *JAMA Pediatrics* 168 (12): 1101–06.
- Lipton, Brandy J., Sandra L. Decker, and Benjamin D. Sommers. 2017. "The Affordable Care Act Appears to Have Narrowed Racial and Ethnic Disparities in Insurance Coverage and Access to Care among Young Adults." *Medical Care Research and Review*, April. <https://doi.org/10.1177/1077558717706575>.
- 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 US Census Bureau. Washington, DC: Urban Institute.
- Maclean, Johanna Catherine, and Brendan Saloner. 2019. "The Effect of Public Insurance Expansions on Substance Use Disorder Treatment: Evidence from the Affordable Care Act." *Journal of Policy Analysis and Management* 38 (2): 366–93.
- McMorrow, Stacey, Jason A. Gates, Sharon K. Long, and Genevieve M. Kenney. 2017. "Medicaid Expansion Increased Coverage, Improved Affordability, and Reduced Psychological Distress for Low-Income Parents." *Health Affairs* 36 (5): 808–18. <https://doi.org/10.1377/hlthaff.2016.1650>.
- McMorrow, Stacey, Genevieve M. Kenney, Sharon K. Long, and Nathaniel Anderson. 2015. "Uninsurance among Young Adults Continues to Decline, Particularly in Medicaid Expansion States." *Health Affairs* 34 (4): 616–20. <https://doi.org/10.1377/hlthaff.2015.0044>.
- Miller, Sarah, and Laura R. Wherry. 2019. "Four Years Later: Insurance Coverage and Access to Care Continue to Diverge between ACA Medicaid Expansion and Non-Expansion States." *AEA Papers and Proceedings* 109 (May): 327–33. <https://doi.org/10.1257/pandp.20191046>.
- Myerson, Rebecca, Samuel Crawford, and Laura R. Wherry. 2020. "Medicaid Expansion Increased Preconception Health Counseling, Folic Acid Intake, and Postpartum Contraception: Study Examines the Impact of ACA Medicaid Expansion on Health Behaviors including Birth Control Use and Pregnancy Intention, and Receipt of Preconception Health Services." *Health Affairs* 39 (11): 1883–90
- Schneider, Karen L., Melissa A. Clark, William Rakowski, and Kate L. Lapane. 2012. "Evaluating the Impact of Non-Response Bias in the Behavioral Risk Factor Surveillance System (BRFSS)." *Journal of Epidemiology and Community Health* 66 (4): 290–95.

- Simon, Kosali, Aparna Soni, and John Cawley. 2017. "The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the First Two Years of the ACA Medicaid Expansions." *Journal of Policy Analysis and Management* 36 (2): 390–417. <https://doi.org/10.1002/pam.21972>.
- Sommers, Benjamin D., Thomas Buchmueller, Sandra L. Decker, Colleen Carey, and Richard Kronick. 2013. "The Affordable Care Act Has Led to Significant Gains in Health Insurance and Access to Care for Young Adults." *Health Affairs* 32 (1): 165–74. <https://doi.org/10.1377/hlthaff.2012.0552>.
- Sommers, Benjamin D., and Richard Kronick. 2012. "The Affordable Care Act and Insurance Coverage for Young Adults." *JAMA* 307 (9): 913–14. <https://doi.org/10.1001/jama.307.9.913>.
- Sommers, Benjamin D., Bethany Maylone, Kevin H. Nguyen, Robert J. Blendon, and Arnold M. Epstein. 2015. "The Impact of State Policies on ACA Applications and Enrollment among Low-Income Adults in Arkansas, Kentucky, and Texas." *Health Affairs* 34 (6): 1010–18.
- Substance Abuse and Mental Health Services Administration and Office of the Surgeon General. 2016. *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: US Department of Health and Human Services.
- Wen, Hefei, Jason M. Hockenberry, Tyrone F. Borders, and Benjamin G. Druss. 2017. "Impact of Medicaid Expansion on Medicaid-Covered Utilization of Buprenorphine for Opioid Use Disorder Treatment." *Medical Care* 55 (4): 336–41.
- Wallace, Jacob, and Benjamin D. Sommers. 2015. "Effect of Dependent Coverage Expansion of the Affordable Care Act on Health and Access to Care for Young Adults." *JAMA Pediatrics* 169 (5): 495–97.



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