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Adults In The Income Range For The Affordable Care Act's Medicaid Expansion Are Healthier Than Pre-ACA Enrollees

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ABSTRACT The Affordable Care Act (ACA) has dramatically increased the number of low-income nonelderly adults eligible for Medicaid. Starting in 2014, states can elect to cover individuals and families with modified adjusted gross incomes below a threshold of 133 percent of federal poverty guidelines, with a 5 percent income disregard. We used simulation methods and data from the Medical Expenditure Panel Survey to compare nondisabled adults enrolled in Medicaid prior to the ACA with two other groups: adults who were eligible for Medicaid but not enrolled in it, and adults who were in the income range for the ACA's Medicaid expansion and thus newly eligible for coverage. Although differences in health across the groups were not large, both the newly eligible and those eligible before the ACA but not enrolled were healthier on several measures than pre-ACA enrollees. Twenty-five states have opted not to use the ACA to expand Medicaid eligibility. If these states reverse their decisions, their Medicaid programs might not enroll a population that is sicker than their pre-ACA enrollees. By expanding Medicaid eligibility, states could provide coverage to millions of healthier adults as well as to millions who have chronic conditions and who need care.

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The Affordable Care Act (ACA) seeks to dramatically increase the number of low-income nonelderly adults who are eligible for Medicaid. Eligibility for this federal-state program has traditionally been restricted to low-income pregnant women; poor children; elderly people; people with disabilities; and, to varying degrees, the parents of poor children. Little coverage has been available to childless adults. In 2009 only six states provided full Medicaid benefits to some childless adults, and twelve states provided more-limited Medicaid benefits.[1] However, many of these programs were closed to new applicants. In 2009 an additional nineteen states extended coverage to some people ages nineteen and twenty.[2]

Beginning in 2014, states can elect to offer Medicaid coverage to adults whose incomes do not exceed an effective threshold of 138 percent of the federal poverty level (133 percent of poverty with a 5 percent income disregard). Adults whose incomes are at or below 138 percent of poverty and who were not eligible for full Medicaid benefits under their state's eligibility rules in December 2009 are termed *newly eligible*.[3]

Even if a state decides not to expand coverage under the ACA, it may still experience increased enrollment. This is because Medicaid, like all public programs, has populations that are eligible but not enrolled. The outreach efforts related to the ACA and the rollout of private insurance through state and federal exchanges, also known as Marketplaces, may prompt adults who had been eligible before the ACA to enroll now.[4]

The newly eligible and adults who were eligible

before the passage of the ACA but not enrolled have different fiscal implications for states. States and the federal government share the costs of the Medicaid program. States pay for none of the care for the newly eligible from 2014 through 2016, with states' shares gradually rising to 10 percent between 2017 and 2020. For the pre-ACA eligible, including those not yet enrolled, each state generally must pay its usual share of expenditures for care—which ranged from 26 percent to 50 percent across the states in fiscal year 2013—with the federal government paying the remainder. The exception is the seven or so states that expanded eligibility for both parents and childless adults with incomes up to or exceeding 100 percent of poverty prior to March 2010: These states receive a higher match rate from the federal government for some adults, but the federal government has not yet determined which of those states will qualify.

States, the federal government, and providers can use information about the characteristics of adults who are newly eligible for Medicaid and of those eligible before the ACA but not enrolled to help implement the ACA. Pre-ACA insurance status among these two groups of adults is a key characteristic, because it will likely influence their decisions about enrolling in Medicaid.

Knowing details about the demographic characteristics of the target population could help states, plans, providers, and advocates for eligible populations conduct outreach. Knowing the health status of newly eligible adults could help states understand what services those adults are likely to need and the potential costs of the services for the federal and state governments.[5–8] We compared the target population with pre-ACA enrollees—a population more familiar to state policy makers.

In addition, comparing pre-ACA enrollees and adults eligible before the ACA but not enrolled can shed light on the extent to which less healthy members of an eligible population enroll. States could be concerned about how enrollment patterns by health status affect their share of the costs of covering the ACA expansion population after 2016, when the percentage of costs they must pay will gradually rise from zero, reaching 10 percent in 2020.

Study Data And Methods

We used simulation methods and data from the Medical Expenditure Panel Survey (MEPS) to compare nonelderly adults enrolled in Medicaid, those eligible before the ACA but not enrolled, and those likely to be newly eligible. Simulation methods have been used in previous studies to inform state policy options under the ACA.[9–11]

STUDY ADVANTAGES Our study has four advantages. First, it used a large number of health status measures. Second, we built on previous studies[5,6] by better identifying newly eligible adults, especially by distinguishing between the newly Medicaid-eligible and those eligible before the ACA but not enrolled.

Third, we excluded adults enrolled in Medicaid because of disability. The adults in this group differ from other adults in numerous ways. For example, compared to other adults in Medicaid, their health status is poorer, and their per capita Medicaid expenditures are five times higher, on average.[12] As we show below, both adults eligible before ACA but not enrolled and adults who are newly eligible have health profiles that are similar to—indeed, even better than—those of nondisabled pre-ACA Medicaid enrollees. Thus, including the adults enrolled because of disability would lead to incorrect conclusions about the extent to which sicker adults enroll in Medicaid.

Fourth, our results are for both the United States as a whole—assuming that all states were to expand Medicaid eligibility—and for states that are expanding Medicaid eligibility to adults targeted by the ACA and states that are not.

MEDICAL EXPENDITURE PANEL SURVEY MEPS is a nationally representative household survey of the civilian noninstitutionalized population.[13] Each year a new panel of households is sampled and interviewed five times in a two-and-a-half-year period to obtain annual data for two consecutive years. To obtain larger samples, we pooled data from six years, 2005–10. We report "point in time" insurance and eligibility at the first interview in each calendar year.

MEPS collects detailed information that facilitates simulating Medicaid eligibility, such as amounts and types of income and assets, family relationships, and pregnancy status. MEPS also collects data on health, demographic characteristics, and attitudes.

We measured general health with the widely used twelve-item Short-Form Health Survey (SF-12) in MEPS.[14] Physical and mental health summary components of the SF-12 were created from twelve questions on topics including general health, pain, energy level, affect, and limitations in physical and major activities. Higher scores indicate better health.

To assess mental health, we used two validated measures that are based on reported symptoms. Serious psychological distress was assessed using a six-question scale.[15] We used two screening questions to measure the prevalence of depressive symptoms.[16]

MEPS asks whether a doctor ever told the sample member that she or he had certain chronic conditions, such as diabetes. MEPS calculates

Knowing the health status of newly eligible adults could help states understand what services those adults are likely to need.

obesity from reported height and weight. For details about the chronic conditions, see the online Appendix.[17]

THE PUBSIM MODEL The PUBSIM model uses detailed, state-specific Medicaid eligibility rules and MEPS to simulate adult eligibility for Medicaid. PUBSIM simulates the numerous pathways to pre-ACA Medicaid eligibility, which vary across states and years. Eligibility under the ACA was simulated using final federal regulations for Medicaid eligibility based on modified adjusted gross income (MAGI), assuming that all states elected to expand coverage.[18] Further details about PUBSIM are available in the online Technical Appendix.[17]

GROUPS OF ADULTS We divided nonelderly adults ages 19–64 who were not Medicare beneficiaries into three groups. The first group consisted of pre-ACA enrollees in Medicaid. As explained above, we excluded those who were eligible because of disability. We also excluded those who had only limited benefits, which were typically offered through state-specific waiver programs and eligibility because of pregnancy.

We classified adults as pre-ACA eligible but not enrolled—our second group—if they were eligible for full Medicaid benefits and their MAGIs did not exceed 138 percent of poverty. This category also included adults with higher incomes (above 138 percent of poverty but not exceeding the pre-ACA eligibility threshold) in the two states that will continue to offer eligibility for full benefits to higher-income adults.

The third group consisted of adults who were newly eligible for Medicaid under the ACA, including those previously eligible for limited benefits. Under the ACA, *newly eligible adults* are defined as those whose MAGIs do not exceed 138 percent of poverty and who were not eligible for full Medicaid benefits under their states' rules as of December 2009. We included with the newly eligible adults people who would be newly eligible if their states expanded Medicaid.

GROUPS OF STATES We compared adults in two groups of states. The first group consisted of the states that were expanding Medicaid to cover adults with MAGIs of up to 138 percent of poverty in early 2014—as of this writing, twenty-five states and the District of Columbia. The second group consisted of the twenty-five states that were not expanding Medicaid in early 2014 but that might do so in the future.[19]

STATISTICS All of our estimates used sampling weights to generate nationally representative, average annual estimates for the period 2005–10. All statistical tests and confidence intervals accounted for the complex design of MEPS, but not for additional variation associated with simulation.

LIMITATIONS The main limitations for our study are as follows. First, PUBSIM generates estimates for eligibility at a point in time, but income—and thus Medicaid eligibility—can change throughout the year.[20] Second, we studied simulated eligibility because true eligibility for Medicaid was not directly measured. Third, our eligibility estimates could be sensitive to macroeconomic conditions and demographic trends that were not projected and to ACA rules and state decisions that had not been finalized.

Two additional limitations were addressed in sensitivity analyses and are described in detail in the online Appendix.[17] First, we did not simulate enrollment decisions by individuals and families. Instead, we focused on uninsured people who were eligible for Medicaid and those who had insurance through the nongroup market and state and local programs. We did this because those adults may be more likely to enroll in Medicaid than adults with employment-related insurance. However, our main results were robust when we included newly eligible adults with employment-related insurance. Even among eligible adults without employment-related insurance, differential participation by health status could affect the results, particularly if adults who are less healthy are more likely to enroll.[6]

Second, the total prevalence of chronic conditions is likely to be higher than reported in MEPS, because some conditions were not diagnosed. Evidence from another study[5] suggests that the prevalence of undiagnosed conditions does not differ by insurance status.[17] Furthermore, obesity, an important chronic condition, was calculated from reported height and weight. Weight could have been underreported, but it is unlikely that such underreporting was correlated with insurance status. The prevalence of obesity followed the same pattern as diagnosed conditions across the three eligibility groups.

Study Results

We used data from the period 2005–10. Our point-in-time estimates indicate that on average, 4.4 million adults (95% confidence interval: 4.0, 4.7) were eligible but not enrolled, compared with 6.8 million (95% CI: 6.3, 7.3) enrolled in Medicaid through a nondisability pathway. Another 23.3 million adults (95% CI: 22.3, 24.3) were newly eligible. These estimates do not reflect changes in the economy, demographic characteristics, or the health sector between the study period and 2014.

INSURANCE STATUS Among newly eligible adults, 60.9 percent were uninsured before the ACA; 30.5 percent had employment-related insurance; 2.8 percent had Medicaid with limited benefits; and 5.8 percent had other coverage, either private insurance not through an employer (individual or nongroup insurance) or another government program (Exhibit 1). Among the pre-ACA eligible but not enrolled, 71.0 percent were uninsured, 24.0 percent had employment-related insurance, and 5.0 percent had other coverage.

ADULTS WITHOUT EMPLOYMENT-RELATED INSURANCE The rest of our analysis focused on uninsured eligibles and those with insurance through the nongroup market and state and local programs, because these adults may be more likely to enroll in Medicaid than those with employment-related insurance. The average point-in-time populations in 2005–10 without employment-related insurance were 3.3 million pre-ACA eligible but not enrolled (95% CI: 3.0, 3.6) and 16.2 million newly eligible (95% CI: 15.4, 17.0).

DEMOGRAPHICS Exhibit 2 compares the demographic characteristics of the newly eligible and pre-ACA eligible but not enrolled with those of the pre-ACA enrollees. The categories of pre-ACA enrollees and those eligible before ACA but not enrolled had small differences in their regional distributions. In comparison, the newly eligible were more concentrated in the South. Pre-ACA enrollees and those eligible but not enrolled were also similar in their age distribution, while the newly eligible had a greater proportion of adults ages 45 and older.

Both groups not enrolled before the ACA were more likely than pre-ACA enrollees to be male and to be single males (Exhibit 2). Among the newly eligible, 28.9 percent had minor children, in contrast with about three-quarters of pre-ACA enrollees and those eligible but not enrolled. The newly eligible were more likely than pre-ACA enrollees to be non-Hispanic whites (54.2 percent); nonetheless, Hispanics and non-Hispanic blacks accounted for 21.3 percent and 17.4 percent of the newly eligible, respectively. The pre-ACA eligible but not enrolled were less likely than pre-ACA enrollees to be non-Hispanic blacks and more likely to be Hispanic. The newly eligible were also slightly more likely than pre-ACA enrollees to be comfortable speaking English (93.1 percent versus 90.8 percent); those eligible before the ACA but not enrolled were similar to pre-ACA enrollees in terms of their comfort speaking English. The newly eligible tended to have more education than pre-ACA enrollees did.

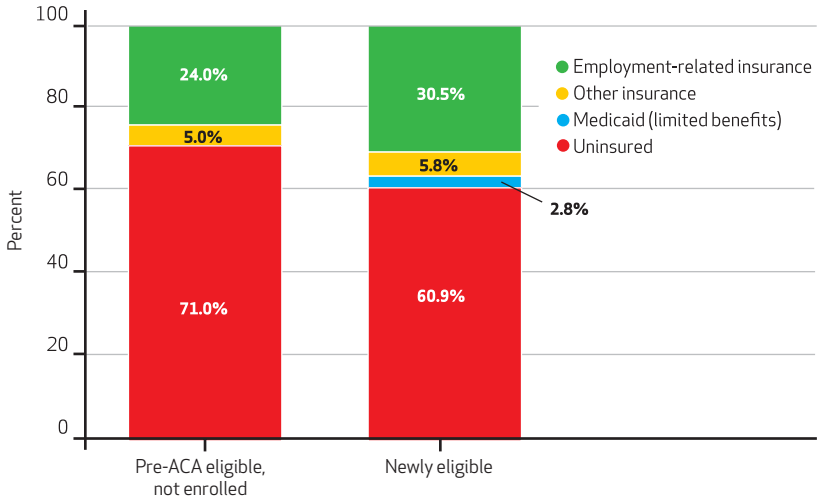
ATTITUDES Exhibit 2 also presents information on attitudes about health insurance, risks, and care seeking—factors that may affect a person's decision about enrolling in Medicaid. Compared with pre-ACA enrollees, newly eligible and pre-ACA eligible but nonenrolled adults were more likely to believe that they did not need health insurance, were "more likely to take risks than the average person," and could "overcome illness without the help of a medically trained person."

These attitudes were held by only a minority of adults likely to be eligible for Medicaid. However, people with such attitudes may be less likely than others to enroll.

HEALTH STATUS On average, adults who were newly eligible for Medicaid or pre-ACA eligible but not enrolled had equal or better physical and mental health and fewer depressive symptoms than pre-ACA enrollees (Exhibit 3). For example, compared with pre-ACA Medicaid enrollees, peo-

EXHIBIT 1

Insurance Coverage Of Nonelderly Adults Not Enrolled In Medicaid Before Implementation Of The Affordable Care Act (ACA), By Medicaid Eligibility



SOURCE Authors' average annual estimates from the Medical Expenditure Panel Survey (MEPS), 2005–10. **NOTES** Ages 19–64. Adults with Medicare are excluded. Insurance coverage and Medicaid eligibility are as of the first MEPS interview of the calendar year. "Newly eligible" are adults in the income range targeted for the eligibility expansion, whether or not their state expands eligibility for Medicaid. "Employment-related insurance" includes TRICARE, the Department of Defense's health care program. "Other insurance" is private insurance not through an employer (individual or nongroup insurance) or government program other than Medicaid.

EXHIBIT 2

Demographic Characteristics And Attitudes About Health Of Nonelderly Adults, By Medicaid Enrollment And Eligibility

Characteristic	Pre-ACA enrollees	Pre-ACA eligible, not enrolled	Newly eligible
Number of observations	6,005	3,352	12,559
GEOGRAPHICAL LOCATION			
Region			
Northeast	28.3%	32.3%	10.0%***
Midwest	22.2	19.3*	19.7*
South	19.9	23.0*	46.7***
West	29.7	25.4*	23.6***
Metropolitan Statistical Area	84.9	85.8	81.3**
AGE, YEARS			
19–29	42.8	42.1	42.5
30–44	37.8	39.1	26.1***
45–54	12.7	12.5	17.8***
55–64	6.7	6.3	13.5***
SEX			
Men	28.9	42.1***	50.5***
Women	71.1	57.9***	49.5***
MARITAL STATUS AND SEX			
Married men	14.6	14.9	13.1**
Married women	19.2	14.5***	13.7***
Single men	14.3	27.2***	37.5***
Single women	51.9	43.4***	35.7***
PARENT OR CARETAKER OF MINOR CHILDREN			
Yes	76.5	72.3**	28.9***
No	23.5	27.7**	71.1***
RACE OR ETHNICITY			
Non-Hispanic white	41.7	44.4	54.2***
Non-Hispanic black	25.3	19.0***	17.4***
Non-Hispanic other	7.9	7.2	7.2
Hispanic	25.1	29.4**	21.3**
ENGLISH PROFICIENCY			
Comfortable speaking English	90.8	89.3	93.1***
EDUCATION			
Did not complete high school or GED	31.7	30.8	24.9***
High school or GED	41.3	39.0	40.5
Some college	20.9	22.5	24.1***
College degree	6.1	7.7	10.4***
AGREED WITH THE FOLLOWING STATEMENTS			
I am healthy enough that I do not need health insurance	9.4	14.5***	16.1***
I am more likely to take risks than the average person	22.1	26.8***	29.7***
I can overcome illness without the help of a medically trained person	20.1	27.5***	26.8***

SOURCE Authors' average annual estimates from the Medical Expenditure Panel Survey (MEPS), 2005–10. **NOTES** Adults with Medicare, Medicaid because of disability, and employment-related insurance are excluded. Medicaid enrollment and eligibility are as of the first MEPS interview of the calendar year. "Newly eligible" are adults in the income range targeted for the eligibility expansion, whether or not their state expands eligibility for Medicaid. Some percentages may not sum to 100 because of rounding. Significance is compared with pre–Affordable Care Act (ACA) Medicaid enrollees. GED is completed general education development or equivalent test. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$

ple who were pre-ACA eligible but not enrolled had higher mean scores (indicating that they were healthier) on the SF-12 physical and mental health summary components and were less likely to report symptoms of serious psychological distress.

Chronic conditions tended to be less prevalent among adults who were newly eligible and pre-ACA eligible but not enrolled than among pre-ACA enrollees (Exhibit 3). For example, 35.3 percent of pre-ACA enrollees were obese, compared with 28.4 percent of the newly eligible and 28.8 percent of the pre-ACA eligible but nonenrolled. And 62.1 percent of pre-ACA enrollees had at least one of the chronic conditions we measured, compared to 57.1 percent of the newly

EXHIBIT 3

Health Status Of Nonelderly Adults, By Medicaid Enrollment And Eligibility

Health status	Pre-ACA enrollees	Pre-ACA eligible, not enrolled	Newly eligible
GENERAL HEALTH, MEAN SUMMARY COMPONENTS OF THE SHORT FORM 12[a]			
Physical	49.4	50.8***	49.8
Mental	48.0	49.2***	48.5*
PERCENT WITH MENTAL HEALTH SYMPTOMS			
Depressive symptoms[b]	16.5%	12.6%***	14.4%**
Serious psychological distress[c]	9.7	7.3***	9.3
PERCENT WITH CHRONIC CONDITIONS			
Active asthma	7.8	5.3***	5.6***
Arthritis	27.7	23.4***	30.1**
Diabetes	7.7	5.1***	5.9***
Emphysema	1.6	0.8**	1.6
Heart disease	8.8	5.7***	7.9
High blood pressure	17.2	12.8***	16.1
High cholesterol	16.8	12.2***	16.4
Obesity	35.3	28.8***	28.4***
Stroke	1.5	1.1	1.9*
1 or more conditions	62.1	52.7***	57.1***

SOURCE Authors' average annual estimates from the Medical Expenditure Panel Survey (MEPS), 2005–10. **NOTES** For number of observations, see Exhibit 2. Ages 19–64. Adults with Medicare, Medicaid because of disability, and employment-related insurance are excluded. Medicaid enrollment and eligibility are as of the first MEPS interview of the calendar year. "Newly eligible" are adults in the income range targeted for the eligibility expansion, whether or not their state expands eligibility for Medicaid. Significance is compared with pre–Affordable Care Act (ACA) Medicaid enrollees. [a]Twelve-item short-form health survey (see Note 14 in text). The higher the values of the summary components, the better the respondent's health. [b]Based on the Patient Health Questionnaire-2 (see Note 16 in text). [c]Based on the Kessler Index (see Note 15 in text). *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$

eligible and 52.7 percent of the eligible but nonenrolled.

STATES Among adults who were newly eligible and not covered by employment-related insurance, 53.7 percent lived in states that were not expanding adult Medicaid eligibility. Comparisons of the demographics of the newly eligible population in the two groups of states are presented in Appendix Table 6.[17]

We observed similar patterns of health status and conditions across enrollment and eligibility groups when we focused on the nation as a whole and when we grouped states by whether or not they were expanding Medicaid eligibility in early 2014 (Exhibit 4). For example, the health status of the newly eligible was similar across the two groups of states. And in both groups of states, the newly eligible were generally healthier than pre-ACA Medicaid enrollees. The newly eligible had lower rates of obesity, active asthma, and diabetes and were less likely to have one or more chronic conditions. In the states that were expanding Medicaid, however, the newly eligible were more likely than pre-ACA enrollees to have arthritis.

Although the newly eligible population had better health than pre-ACA enrollees, the number of newly eligible adults will likely change the volume of the Medicaid caseload with chronic conditions because of the large increase in the total number of eligible adults. In states that have elected to expand Medicaid, if all eligible adults without employment-related insurance enrolled in the program, the number of adult Medicaid enrollees who were not eligible through a disability pathway would be three times higher than the number of adults who had Medicaid with full benefits before the ACA. In these states an additional 5.4 million (95% CI: 5.0, 5.9) adults with diagnosed chronic conditions would have full benefits, bringing the total to 2.8 times the number before the ACA, 3.0 million (95% CI: 2.7 million, 3.3 million).

Eligibility thresholds are low in states that are not expanding Medicaid in early 2014.[19] If all eligible adults without employment-related insurance in these states enrolled in the program, an additional 0.5 million (95% CI: 0.4 million, 0.6 million) adults with diagnosed chronic conditions would have full benefits.

In these states, there were 8.7 million (95% CI: 8.0, 9.4) adults in the income range targeted for the eligibility expansion and lacking employment-related insurance. Based on their reported incomes, we estimated that 34.0 percent were eligible for subsidies in the Marketplaces, and 66.0 percent were not eligible for Medicaid or for Marketplace subsidies. There were 5.0 million (95% CI: 4.6, 5.5) adults with diagnosed chronic conditions who would not be eligible for Medicaid unless those states elected to expand coverage.

Discussion

Adults who were eligible for Medicaid but not enrolled before passage of the ACA and those in the income range for the ACA's Medicaid expansion ("newly eligible") had similar or better health than adults enrolled in Medicaid through a pathway other than disability before the ACA—in spite of the fact that the newly eligible were somewhat older than the currently enrolled.

The pattern of results was similar for physical and mental health, and whether health was measured with validated symptom-based scales or reports of chronic conditions. Even in states that are not expanding Medicaid in early 2014, adults in the income range for the ACA's Medicaid expansion were healthier than pre-ACA enrollees.

Moreover, in an alternative analysis described in the Appendix,[17] we found that the newly eligible were not less healthy than the pre-ACA eligible (combining both enrollees and those eligible but not enrolled). The newly and pre-ACA eligi-

EXHIBIT 4

Health Status Of Nonelderly Adults In States That Are Expanding Medicaid Eligibility And States That Are Not, By Medicaid Enrollment And Eligibility

	States expanding eligibility			States not expanding eligibility		
Health status	**Pre-ACA enrollees**	**Pre-ACA eligible, not enrolled**	**Newly eligible**	**Pre-ACA enrollees**	**Pre-ACA eligible, not enrolled**	**Newly eligible if states were expanding**
Number of observations	4,392	2,457	5,608	1,613	895	6,951
GENERAL HEALTH, MEAN SUMMARY COMPONENTS OF THE SHORT FORM 12[a]						
Physical	49.6	51.3***	50.0	48.8	49.5	49.6*
Mental	48.0	49.7***	48.3	47.9	47.9	48.7*
PERCENT WITH MENTAL HEALTH SYMPTOMS						
Depressive symptoms[b]	16.3%	11.4%***	14.6%	16.8%	15.8%	14.3%*
Serious psychological distress[c]	9.6	6.1***	9.5	10.0	10.5	9.2
PERCENT WITH CHRONIC CONDITIONS						
Active asthma	7.9	5.0***	5.8**	7.6	6.1	5.4**
Arthritis	26.4	21.3***	30.2***	30.9	29.4	30.0
Diabetes	7.2	5.3**	5.7**	8.8	4.6***	6.1***
Emphysema	1.3	0.7	1.4	2.4	1.2[d]	1.8
Heart disease	7.9	5.5***	7.7	11.0	6.3***	8.0**
High blood pressure	16.1	12.5***	15.1	19.9	13.9***	17.0*
High cholesterol	17.0	12.6***	17.1	16.4	11.3**	15.8
Obesity	33.7	27.0***	27.0***	39.6	33.8**	29.7***
Stroke	1.3	1.0	1.5	1.9	1.6[d]	2.2
1 or more conditions	61.2	50.3***	56.1***	64.4	59.6	57.9***

SOURCE Authors' average annual estimates from the Medical Expenditure Panel Survey, 2005–10. **NOTES** Ages 19–64. Adults with Medicare, Medicaid because of disability, and employment-related insurance are excluded. Medicaid enrollment and eligibility are as of the first MEPS interview of the calendar year. "Newly eligible" are adults in the income range targeted for the eligibility expansion, whether or not their state expands eligibility for Medicaid. Significance is compared with pre–Affordable Care Act (ACA) Medicaid enrollees in their group of states. [a]Twelve-item short-form health survey (see Note 14 in text). The higher the values of the summary components, the better the respondent's health. [b]Based on the Patient Health Questionnaire-2 (see Note 16 in text). [c]Based on the Kessler Index (see Note 15 in text). [d]Relative standard error exceeds 0.3. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$

ble were similar in global measures of health and in the percentage that had at least one chronic condition.

Two other studies have also found that pre-ACA enrolled adults were less healthy than adults who would be eligible under the expansion (combining the newly eligible and the pre-ACA eligible but not enrolled). Compared with a study by Sandra Decker and coauthors that used data from the National Health and Nutrition Examination Survey,[5] we found smaller differences in health between the two groups. This was because we excluded adults who were eligible because of disability—a population with considerably worse health than other Medicaid enrollees.[12] We also found smaller health differences than John Holahan and colleagues reported,[6] because they measured the treated prevalence of chronic conditions, whereas we used diagnosed prevalence. Compared to people with coverage and the same health status, the uninsured are less likely to be treated. Thus, the treated prevalence of their conditions is lower than the diagnosed prevalence.

Policy Implications

FOR STATES EXPANDING ELIGIBILITY Our findings could have implications for the likely degree of adverse selection among newly eligible adults. Medicaid experiences adverse selection when enrollment rates are higher among sicker people than among healthier people.

Using the health status measures available in MEPS, we found that before the ACA, Medicaid experienced only modest adverse selection: Enrollees were less healthy than people who were eligible but not enrolled, but the differences—although statistically significant—were not large. Differences in the prevalence of most conditions and symptoms were in the range of 2–5 percentage points. But 62.1 percent of Medicaid enrollees had one or more chronic conditions, compared with 52.7 percent of those eligible but not enrolled (Exhibit 3).

These findings might appear to be at odds with findings reported by Stephen Somers and coauthors.[7] Using administrative data on the health care costs of enrollees in state programs and pre-ACA Medicaid expansions for childless

adults, they found that childless adult enrollees had much higher costs than other nondisabled adult Medicaid enrollees. However, nearly all of the states studied by Somers and colleagues had enrollment caps, which the authors note might have caused disproportionate enrollment by adults with health problems.

Indeed, we also found more adverse selection when we examined the subset of childless adults (Appendix Table 5).[17] The magnitude of the difference was similar to that found in an analysis of Connecticut's recent expansion of Medicaid to childless adults.[21] Our results suggest that expansions of Medicaid to childless adults before the ACA, which capped enrollment in some states, could have different enrollment patterns than the uncapped ACA expansion. We found less adverse selection than Somers and colleagues did. However, we did find more in our analysis of programs for childless adults than in our main analysis.

The potential growth in Medicaid enrollment has implications for planning to meet the needs of future enrollees. Of course, not all eligible adults will enroll, and take-up could be particularly low among the third of people who were eligible for Medicaid before the ACA but who were covered through employment-related insurance.

Nevertheless, if all adults without employment-related insurance who become eligible for Medicaid in 2014 enroll, then the number of nondisabled adults with chronic conditions in the program will likely be 2.8 times the pre-ACA numbers in the states that expand eligibility. This increase is entirely due to the growth in the number of enrollees, because the newly eligible are less likely than pre-ACA enrollees to have chronic conditions. States might wish to determine whether or not services are available to meet the needs of these new enrollees.

FOR STATES NOT EXPANDING ELIGIBILITY

States that are not expanding eligibility could nonetheless experience increased enrollment from a somewhat healthier pool of adults who were eligible before the ACA. In 2014 states are responsible for a portion of Medicaid expenditures for this population.

The number of newly eligible adults will likely change the volume of the Medicaid caseload with chronic conditions.

There is a much larger group of adults—8.7 million (95% CI: 8.0, 9.4)—who are in the income range targeted for the eligibility expansion and who lack employment-related insurance. We estimated that 66 percent of this population had incomes too low to participate in the health insurance Marketplaces. More than half of this population had chronic conditions, and these adults are likely to have difficulty paying for care and may instead obtain uncompensated care. Expanding Medicaid eligibility could help this population.

Conclusion

Adults in the income range for the ACA's Medicaid expansion had similar or better health than adults enrolled in Medicaid through a pathway other than disability before the ACA. As of January 2014, twenty-five states had decided not to use the ACA to expand Medicaid eligibility for adults. If these states reverse their decisions, their Medicaid programs might be unlikely to enroll a population that is sicker than their pre-ACA enrollees. By electing to expand Medicaid eligibility, states could provide coverage to millions of healthier adults as well as to millions who have chronic conditions and who need care. ■

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