

Medicaid: Expanded and Still Uninsured
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Abstract

The Affordable Care Act expanded eligibility for Medicaid, a program which provides government-funded health insurance to low-income households. However, research finds that with expansion efforts, there may be a lag in take-up given some information and process costs that are associated with understanding new eligibility criteria. With Medicaid expansion, millions of Americans are now eligible, and yet, an estimated four million eligible people have not taken advantage of the program. This paper explores under what conditions Medicaid-eligible individuals, who do not have health insurance, fail to enroll, taking into account marginal take-up. Using data from the Current Population Survey, I find newly-eligible adults with no dependents are still 1.6 times more likely to be uninsured than those who do have dependents. I also find distinct differences between racial and ethnic groups. Black Americans were 1.6 times more likely to be uninsured in comparison to White Americans, and Hispanic Americans were 2.4 times more likely to be uninsured.

Keywords: social benefits, social policy, Medicaid, health insurance

1. Introduction

In the United States there are about 27 million people who lack health insurance and about four million individuals who are eligible for free insurance from the government, and yet, fail to claim it (Garfield et al., 2016). The Affordable Care Act (ACA), enacted in 2010 under President Obama, sought to increase health coverage, while keeping the private market as the primary source for health insurance. Instead of a public universal system, the U.S sought to cover every American—in segments—by employing a complex policy that was considered the “no wrong door” approach (Dubay et al., 2014, p. 3)

Under the ACA every American is required to have health insurance and before 2019, there was a financial penalty for those who did not comply.¹ To incentivize enrollment, individuals with incomes between 100 to 400 percent of the federal poverty limit (FPL) qualified for subsidies when purchasing health insurance on the private market. The passage of the ACA

¹ In 2017, Congress passed a law that eliminated the financial penalty associated with the individual mandate for health insurance. This law went into effect in 2019.

also allowed states to expand the eligibility criteria for Medicaid. This reform was the largest expansion of Medicaid since its inception (Blumenthal & Collins, 2014).

Prior to this expansion, Medicaid was only available for children, people with disabilities, pregnant women, and low-income parents. Non-elderly adults over the age of 18 with no dependents and earning low-incomes were often left to purchase health insurance via the private market. The median eligibility for this population was zero percent of the FPL, with only nine states offering some Medicaid coverage to adults without children (Clinton & Sances, 2018). Now, all individuals living in expansion states with incomes at or below 138 percent of the FPL are eligible to enroll.

This paper considers under what conditions individuals who are newly-eligible for Medicaid continue to be uninsured. Undeniably, the uninsured rate has dropped since the implementation of the ACA, from 15.5 percent in 2010 to 8.9 percent in 2018. This debate between a universal system and a means-tested one continues to dominate policy discussions and presidential primaries. In the Democratic primary, the left candidates, Sens. Bernie Sanders and Elizabeth Warren are advocating for a universal system, which will cover all individuals, whereas center candidates former Vice President Joe Biden, Sen. Amy Klobuchar and Mayor Pete Buttigieg argue for a continuation of the piecemeal approach. Policymakers will need to consider the barriers to enrollment and how incremental expansion efforts can fail to capture their target audiences.

The paper is organized as follows. First, I will summarize the previous literature on means-tested programs and theories of why eligible individuals do not participate in government programs. I will then discuss the hypotheses based on the literature. Next, I will outline the data and methodology for the analysis. Thereafter, I will present the findings from the empirical analysis. Lastly, I will discuss how the findings can add to this field of study and highlight opportunities for future research.

2. Literature Review

The U.S. uses a number of tactics to redistribute its wealth and has a safety net that is comprised of both universal and means-tested programs. In the U.S., there are 79 means-tested programs that aim to serve the most vulnerable populations, including the poor, the elderly, the disabled, and children (Rector, 2012). Means-tested programs are designed to target those who meet certain criteria. These criteria can be as restrictive or broad as the government sees fit, but in the case of the U.S. these criteria have been historically restrictive. From an economics perspective, means-tested programs would appear to be superior since funds are only allocated to the population in need. Yet numerous studies have demonstrated that means-tested programs have had mixed results in reaching their target population, and some studies have shown negative results (Soss, 1999). The concept of leaving “money on the table” by not claiming important benefits that can lessen financial burdens can seem illogical. But from a sociological perspective there are a number of theories to explain why

people do not claim their benefits.

Remler (2001) explains that with any decision, individuals will make certain mental calculations to weigh the cost of claiming the benefit with the benefit itself. These costs typically fall into three categories: 1) information costs, 2) process costs, and 3) outcome costs. Information costs refer to the complexity of the program criteria and the energy needed to understand the eligibility requirements. Information costs can also be sensitive to political discourse, in that the dissemination of wrong information can depress take-up. Process costs include the costs of having to apply or enroll in the program. For example, if the enrollment process takes a long time and requires numerous documents to be validated, individuals can delay the process or never enroll. Finally, outcome costs can be characterized by the stigma attached to that program. Goffman defines stigma as an “attribute that is deeply discrediting” (1963, p. 3) and notes the existence of tribal stigma that typically refers to race, religion, nationality and other attributes that are transmitted from one family member to another. This stigma can deter eligible individuals from enrolling in necessary and important public programs. All of these theories can help explain why eligible individuals do not enroll in certain programs, and possibly offer more insight into what groups of individuals are most susceptible to each of these aforementioned costs.

As the largest means-tested program in the U.S., Medicaid is an interesting case to explore. Created in 1966 by President Lyndon B. Johnson, as part of his War on Poverty initiative, Medicaid is a joint federal and state program that provides health insurance to over 64.5 million low-income Americans (Centers for Medicare & Medicaid Services). Unlike cash transfers, the benefits of Medicaid can be hard to quantify. However, research has shown that positive health outcomes can impact underlying conditions, such as poverty and other social determinants (Cohn, 2016). Though, many individuals might not attribute their improved economic standing to their access to health care. Furthermore, if a person is generally healthy, the burden of enrollment—taking into consideration all the theoretical costs—may seem unnecessary or a lower priority at that time.

Individuals who likely qualify for means-tested programs typically have fewer resources at their disposal. These resources can be education, skills, and monetary resources (Soss, 1999). Therefore, reaching this population can also be difficult for governmental agencies, as these individuals may have a harder time overcoming the associated information and process costs with means-tested programs.

2.1. Information Costs

Medicaid has experienced a number of expansions over the years. From a public policy perspective, these are positive developments that expand coverage and ensure more people can receive free health insurance. However, for low-income individuals, these changes can only further blur the line between eligible and ineligible. For example, when Medicaid was first created, it was linked to another public benefit program, Aid to Families with Dependent Children (AFDC), which provided cash assistance to needy families. But in 1996, President

Clinton signed into law welfare reforms that delinked Medicaid from welfare. As a result, individuals who did not otherwise qualify for AFDC but still had low-incomes could now receive Medicaid (Mann, 1999). In the time shortly after the law went into effect, the Medicaid caseload dropped dramatically (Dion & Pavetti, 2000), and one study showed that there was immense confusion among newly-eligible populations (Kandula et al., 2004).

With the passage of the ACA, the government has changed the eligibility requirements again to include childless adults with incomes up to 138 percent of the FPL. Expansion of existing benefits are undoubtedly a positive, however, with expansions two additional considerations must be included in the calculus of uptake. As described by Sommers and colleagues (2012) the average take-up rate is typically higher than the marginal take-up rate. The average take-up refers to the rate at which all eligible individuals enroll in a certain program. The marginal take-up refers to the rate at which newly-eligible individuals enroll. Because it takes time to understand the new requirements the marginal take-up is often lower than the average take-up. The other consideration is the time since implementation. Initial take-up can be lower because it takes time for service providers and individuals alike to understand the new requirements. Given this, I hypothesize that the information costs will be a barrier to newly-eligible populations, specifically childless adults. Furthermore, I suspect that the time since implementation may serve as a moderator to take-up.

2.2. Process Costs

As with any means-tested program, the government has to determine if applicants are, in fact, eligible to receive the benefit. The application process can request a lot from its applicants. This can include certified documents, laborious paperwork, and having to travel to a government office. For individuals and families with few resources and low incomes, the application itself can be a barrier. For example, in one study, 72 percent of Medicaid applicants reported having difficulty acquiring the needed documentation and as a result did not complete the process (Dion & Pavetti, 2000). Individuals who are working and have less free time throughout the week might also forgo enrollment, simply because the process can be burdensome.

This process can appear more complicated to immigrants and particularly those who do not speak English well. In general, immigrants are more likely than their U.S.-born peers to be eligible for Medicaid, as their incomes are typically lower, but their enrollments continue to lag (Kandula et al., 2004). Language barriers are a common issue for immigrants when it comes to any means-tested program, as applications are usually in English and government agencies lack the resources for bilingual staff (Ellwood, 1999). Aizer (2003) found that when governments make a coordinated effort to reach these immigrant communities, outreach can increase enrollment. But, as is true with most means-tested programs, this outreach is often an afterthought. The second hypothesis concerns the effect of process costs on two distinct groups. I hypothesize that process costs will be higher for working adults and immigrants to overcome, and thus lead to higher probabilities of being uninsured.

2.3. Outcome Costs

The question of stigma is a curious one as it relates to Medicaid. While more than half of Americans are in some way connected to Medicaid and its services, name recognition, perception, and reputation can all impact its take-up. As a product of the President Johnson's War on Poverty initiative in 1966, some Americans continue to think of the program as strictly for low-income Americans. As such, the US government has gone to great lengths to rename some of its services, for the purpose of distancing them from Medicaid and encouraging higher take-up. And while these efforts may have increased take-up for select services, at the same time, these efforts may have affected the overall brand of Medicaid.

As Stuber and Schlesinger (2006) explain, being poor in America is often seen by others as being lazy, lacking ambition or work ethic, and even being a bad parent. This is due to the persistent American Dream myth that asserts that anyone from any socioeconomic status can "pull themselves up by their bootstraps" and achieve prosperity; and therefore, anyone who needs public assistance might be looked down upon. They identify two forms of stigma that can impact one's decision to enroll in a public benefit program. The first is identity stigma, which refers to the fear of being thought of in a negative light. This stigma has been seen to affect African Americans in particular, who may be concerned about racist stereotypes of African American work ethic. The second form of stigma relates to treatment. Those affected by this stigma are concerned that service providers, administrators, and even family and friends may treat them differently if they enroll. In their research, Stuber and Schlesinger found that Black respondents had higher levels of identity and treatment stigma than their White counterparts, and Latino respondents had higher levels of treatment stigma than Whites. I hypothesize that African American and Hispanics will be more likely to be uninsured.

3. Data and Methodology

3.1. Current Population Survey

To determine Medicaid enrollment and eligibility, I use data from the 2018 Current Population Survey March supplement (hereafter "CPS"). The CPS is conducted by the Census Bureau and provides comprehensive data related to health insurance, employment and income, demographics and geographic data. Because some states have chosen not to expand the eligibility for Medicaid, the geographic data was critical to this analysis, as the focus of this paper is to better understand who continues to opt out of Medicaid enrollment, despite expansion efforts.

There are some limitations to using the CPS data for the purpose of this paper. Previous literature has expressed that one's self-reported health can impact his or her decision to enroll in Medicaid; however, the CPS does not ask questions related to one's health condition (Davidoff, 2001). Therefore, I was unable to test if people who report being healthy are more

likely to be uninsured. Another limitation of the CPS data is the lack of detail regarding one's immigration status. For example, some legal permanent residents (LPR) are eligible for Medicaid, but only if they have lived in the U.S. for a certain amount of time, and each state has its own criteria with respect to immigrants (Kandula et al., 2004). The CPS does distinguish between citizens and non-citizens, but it does not include information about those with LPR status. Therefore, in this paper, I have restricted the sample to only U.S. citizens, but will use a proxy for the immigrant variable that will be explained in the section below.

3.2. Methodology and Measures

To determine the probability that one will continue to be uninsured despite expansion efforts, I construct a three-level mixed effects logistic regression model, with individuals nested in households nested in states. The dependent variable is the current insurance status, which is coded as zero (0) if the person reports having some kind of health insurance and one (1) if the person states that he or she lacks any kind of insurance. Because I am solely interested in the population who are eligible for Medicaid, any households who did not have at least one individual meet the estimated eligibility requirements were dropped from the sample. This included individuals who lived in a state that did not expand Medicaid. Eighteen states, as of December 31, 2018 had not expanded Medicaid. Any individual who lived in a household with a household adjusted gross income larger than the required maximum was also dropped from the sample. Medicaid eligibility is determined using one's modified adjusted gross income (MAGI) and the number of persons in the household, per guidelines released by the U.S. Department of Health and Human Services (HHS) (Office of the Secretary, Department of Health and Human Services, 2018). I used household adjusted gross income (AGI), which was the closest variable to one's MAGI and followed the HHS guidelines to determine the eligible population. The final sample size was 21,914.

The independent variables of interest are newly-eligible individuals, which are adults with no dependents, immigrant status, and the employment status. While the sample only consists of citizens, I was able to determine those who were born outside of the U.S. I coded the immigrant status variable as 1 if he or she was foreign-born and 0 if the respondent was born in the U.S. Newly-eligible childless adults were defined as any person over the age of 18, who lived in a household with no persons under the age of 18. The employed group is a coded as a dummy variable, with 0 referring to those who are not employed and 1 referring to those who are employed.

I control for a number of factors that have been known to impact enrollment, such as race and ethnicity, which is a categorical variable with five categories: 1) White, 2) African American, 3) Hispanic, 4) Asian, and 5) Other. I include gender, as women are more likely to be enrolled, as are married individuals. I also include the number of persons in the household, age and age squared, given its curvilinear relationship with enrollment and household income. Household income is different from the household AGI as some benefits are not included in household AGI. I also include the highest level of education.

4. Findings

Overall, the uninsured were younger in comparison to their insured counterparts. Women were insured at a slightly higher rate, and Hispanics had the highest uninsured rate in comparison Whites, Blacks, Asians, and other races and ethnicities. The mean household AGI for the uninsured was about \$3,000 higher than the insured population, which is expected as the eligibility criteria increased with expansion. Another factor to consider is that because income can fluctuate from year to year, individuals at or around the cusp of eligibility may not be fully aware of the requirements. Full descriptive statistics are found in Table 1.

Table 1: Descriptive Statistics

Variable	% Uninsured	% Insured	% in Sample
Mean age	35	43	42
Women	7.59%	92.41%	56.38%
Men	9.61%	90.39%	43.62%
Race and ethnicity			
White	5.98%	94.02%	49.63%
Black	8.02%	91.98%	16.61%
Hispanic	13.24%	86.76%	23.75%
Asian	8.79%	91.21%	6.8%
Education			
Less than high school degree	9.38%	90.63%	23.37%
High school degree	9.78%	90.22%	38.76%
Some college degree	8.42%	91.58%	24.89%
College degree	9.33%	90.67%	9.08%
Advanced degree	7.90%	92.10%	3.90%
Mean household AGI	\$16,604	\$13,065	\$13,365
Single adult with no children	6.82%	93.18%	49.12%
Immigrant (foreign-born)			
Employed	18.01%	81.99%	24.57%

Married	9.69%	90.31%	31.94%
Mean number of persons in household	3.73	3.30	3.34
n	1,857	20,057	21,914
Total	8.47%	91.53%	

Source: Current Population Survey 2018

The results from the multilevel mixed effects model are presented in Table 2. I find that being newly-eligible for Medicaid was associated with higher odds of being uninsured (1.6), which is consistent with the first hypothesis. As the literature shows, marginal take-up is typically lower than average take-up as it takes time for individuals to learn about the new criteria and understand how to go about enrollment. When considering time since implementation, we would expect to find that the more time since the implementation of Medicaid expansion in a particular state, the lower the odds ratio. However, I do not find significance in my model for this variable. This might be due to the fact that the time period is still relatively short. Future research may find significance with longer time periods.

Hypothesis two considered process costs, anticipating that immigrants and the employed may encounter barriers to enrollment given the complex application process. The results do reveal higher odds ratios for both groups of individuals. Working adults are 2.46 more likely to be uninsured at a statistically significant level. The immigrant status variable is not significant. This might be due to the make-up of the data. The stigma hypothesis suggested that we would see differences in insurance status based on race and ethnicity. Being Black or Hispanics was associated with higher odds ratios (in relation to Whites), 1.63 and 2.43 respectively, suggesting that stigma may still be at play here.

Among the control variables, I find that women are less likely to be insured, which is somewhat curious, as previous literature has shown that women have a higher rate of insurance than men. Among the education variable, on the high school degree is significant with those with a high school degree being 1.61 times more likely to be insured than those without a high school degree. The other education levels are not statistically significant, but their odds ratio are what we would expect.

Table 2. Logistic Regression of Uninsured, Medicaid-Eligible Individuals

Variable	Odds ratio	95% CI
New eligible group - adults without dependents	1.60** (0.266)	1.15 - 2.22
Immigrant (dummy)	0.94 (0.222)	0.60 - 1.50
Employed (dummy)	2.46*** (0.317)	1.91 - 3.17

Race and ethnicity (ref: White)		
Black	1.63* (0.318)	1.11 - 2.39
Hispanic	2.43*** (0.493)	1.64 - 3.62
Asian	1.07 (0.372)	0.55 - 2.12
Other	3.90*** (1.302)	2.03 - 7.51
Female (dummy)	0.60*** (0.670)	0.48 - 0.75
Education level (ref. Less than high school)		
High school	1.61** (0.278)	1.15 - 2.26
Some college	1.32 (0.248)	0.92 - 1.91
College	1.51 (0.383)	0.92 - 2.48
Advanced	1.63 (0.582)	0.82 - 3.28
Married (dummy)	1.19 (0.183)	0.88 - 1.61
Age	1.34*** (0.034)	1.28 - 1.41
Age squared	0.99*** (.000)	1.00 - 1.00
Household income	1.00*** (0.012)	0.95 - 1.01
Time since implementation (measured in months)	0.98 (0.016)	0.95 - 1.01
Constant	0.0001*** (0.0001)	0.73 - 0.61

Source: Current Population Survey *p<.05; **p<.01; ***p<.001

5. Conclusion

With the passage of the ACA, the U.S. saw the greatest expansion to Medicaid since its creation. This paper, however, found that there continue to be gaps in Medicaid coverage among certain populations. Given the information and process costs that are associated with new eligibility criteria, marginal take-up rates will continue to be lower than that of average

take-up rates. Minority groups, Black and Hispanics and those included in the other category, are more likely to be uninsured when compared with their White peers. Additionally, those who were employed were more likely to be uninsured in the sample, which suggests that more effort is needed to make the enrollment process even simpler. Remler (2001) concluded that short of universality, automatically enrolling individuals is likely the most effective approach to achieving 100 percent coverage. For example, Medicare, which is a universal health insurance program for adults over the age of 65, automatically enrolls individuals in the program, sending a notice to the participant asking if he or she wants to opt out of the program. This approach relieves the potential applicant of the burden of enrollment and ensures participation.

The policymakers who drafted the ACA likely considered the lessons learned from other programs, and included a number of provisions to encourage enrollment in Medicaid and remove barriers to participation. These provisions comprised of simplifying the enrollment process, increasing eligibility requirements, enhancing presumptive eligibility efforts, and improving customer service (Clinton & Sances, 2017). However, this paper reveals that a certain set of the population continues to “leave money on the table.” Future research could measure which of these efforts is the most effective.

This paper focused on states that expanded Medicaid, but there are still many states that chose not to expand coverage, leaving Medicaid eligibility restrictive. There is a growing amount of research that is examining the enrollment differences between these two groups of states. Additionally, it would be useful to explore how enrollment numbers in non-expansion states are affected by the so-called “woodwork effect,” in which previously eligible individuals now choose to enroll, given the media attention around the ACA and Medicaid expansion (Sommers, 2012). This phenomenon could increase overall enrollment and ensure Medicaid-eligible individuals are getting the health care they qualify for.

Lastly, academics and policymakers would benefit from additional qualitative research that examines information, process, and outcomes costs under Medicaid expansion. For instance, has the implementation of Medicaid expansion reduced the outcome costs for certain minority groups? Any expansion in access to health insurance should be lauded, but as the literature shows, means-tested programs can be more expensive to implement and still fail to reach their targeted populations (Stuber & Schlesinger, 2006). Proposals, such as Medicare for All, as promoted by Democratic candidates Bernie Sanders and Elizabeth Warren have gained some traction. But until then, government actors and community leaders will have to work together to reach these vulnerable populations.

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