

Expanded Income Eligibility for Health Insurance






Evidence Review Findings: Effective / Roadmap Policy

Expanding Medicaid eligibility to include most individuals with incomes up to 138 percent of the federal poverty level increases access to needed health care services, improves financial wellbeing, and reduces racial disparities in adverse birth outcomes.

States can employ a number of strategies to increase health insurance coverage for their residents. The evidence in this review focuses on one key strategy that has been widely studied: the expansion of Medicaid eligibility to include most adults with incomes up to 138 percent of the federal poverty level. Medicaid is a joint federal-state program that provides health insurance to low-income households. States set varying eligibility guidelines for childless adults, parents, and pregnant individuals and therefore vary in the percentage of adults that have access to affordable health insurance and care.

Decades of research in the field of child development have made clear the conditions necessary for young children and their families to thrive.¹⁵ These conditions are represented by our eight policy goals, shown in Table 1. The goals positively impacted by Medicaid expansion are indicated below.

Table 1: Impacts of Medicaid Expansion on Policy Goals

Positive Impact	Policy Goal	Overall Findings
	Access to Needed Services	Mostly positive impacts on insurance coverage, mixed impacts on health care use
	Parents' Ability to Work	No strong causal studies identified for this goal
	Sufficient Household Resources	Positive impacts on sufficient resources, especially medical debt and spending on health
	Healthy and Equitable Births	Mixed impacts on adverse birth outcomes overall, with evidence of reductions in racial disparities
	Parental Health and Emotional Wellbeing	Mixed impacts on parental health and emotional wellbeing
	Nurturing and Responsive Child-Parent Relationships	No strong causal studies identified for this goal
	Nurturing and Responsive Child Care in Safe Settings	No strong causal studies identified for this goal
	Optimal Child Health and Development	Trending positive impacts on reducing child neglect rates

What Is Expanded Income Eligibility for Health Insurance?

States can employ a number of strategies to increase health insurance coverage for their residents, such as waiving work requirements for public insurance or offering Marketplace rebates. This review summary focuses on one key strategy that has been widely studied: the expansion of Medicaid eligibility to include most adults with incomes up to 138 percent of the federal poverty level (FPL). The federal Patient Protection and Affordable Care Act (also known as the ACA) was signed into law in 2010. In addition to providing subsidies to purchase health insurance in the online marketplace, the ACA expanded Medicaid eligibility for most adults with incomes up to 138 percent of the FPL, to begin in 2014. However, the Supreme Court ruled the federal expansion unconstitutional in 2012 and gave individual states the power to determine their own income guidelines and eligibility criteria. Therefore, Medicaid expansion has not been implemented in all states.

States that have expanded Medicaid provide coverage to most adults with incomes up to 138 percent of the FPL. States that have not expanded Medicaid do not cover any childless, nonelderly adults,ⁱ regardless of income level, and the income eligibility guideline for parents in nonexpansion states varies, ranging from 17 percent of the FPL in Texas to 100 percent of the FPL in Wisconsin. In all states, regardless of expansion status, Medicaid coverage for pregnant women is set at a higherⁱⁱ eligibility guideline than for childless adults or parents, ranging from 138 percent of the FPL to 380 percent of the FPL; however, this expanded coverage ends 60 days postpartum.ⁱⁱⁱ Table 2 below provides a snapshot comparison of how Medicaid eligibility requirements typically vary during the perinatal period in expansion versus nonexpansion states. A more detailed description of income eligibility guidelines by state is provided in Table 4 at the end of this review.

Table 2: Summary of Medicaid Eligibility Requirements During the Perinatal Period

	Before Pregnancy	During Pregnancy (Through 60 Days Postpartum)	After Pregnancy (61 Days Postpartum)
Expansion States	<ul style="list-style-type: none"> Childless adults with incomes up to 138 percent of the FPL^{iv} Parents with incomes up to 138 percent of the FPL 	<ul style="list-style-type: none"> Pregnancy Medicaid income eligibility determined by each state, ranging from 138 percent to 380 percent of the FPL Pregnant women could move from marketplace to Medicaid 	<ul style="list-style-type: none"> Parents with incomes up to 138 percent of the FPL Some new mothers will move to marketplace and be eligible for subsidies (incomes between 100 and 400 percent of the FPL)
Nonexpansion States	<ul style="list-style-type: none"> Childless adults not eligible for Medicaid Parents' income eligibility determined by each state, ranging from 17 percent to 100 percent of the FPL 	<ul style="list-style-type: none"> Pregnancy Medicaid income eligibility determined by each state, ranging from 138 percent to 306 percent of the FPL Pregnant mothers could move from marketplace to Medicaid 	<ul style="list-style-type: none"> Parents' income eligibility determined by each state, ranging from 17 percent to 100 percent of the FPL Some new mothers will move to marketplace and be eligible for subsidies (incomes between 100 and 400 percent of the FPL)

ⁱ With the exception of Wisconsin, which provides coverage for adults with incomes up to 100 percent of the FPL

ⁱⁱ Higher income guidelines increase the number of individuals eligible for coverage.

ⁱⁱⁱ Interest in extending Medicaid coverage beyond 60 days, up to 12 months postpartum, is increasing. This proposed policy is distinct from state Medicaid expansion through the ACA and is outside the scope of this review.

^{iv} The District of Columbia is an exception and covers childless adults up to 215% of the FPL and parents up to 221% of the FPL. Connecticut has also increased parent income eligibility to 160% of the FPL.

Who Is Affected by Medicaid Expansion?

The populations most affected by state Medicaid expansion are previously ineligible childless adults, including childless women of reproductive age,^v and parents whose incomes fall between the pre-ACA guideline in their state and 138 percent of the FPL. Overall, Medicaid provides health insurance for one in five Americans and covers approximately half of all births in the United States.¹² In 2012, it was estimated that through the ACA, Medicaid expansion could provide insurance coverage to 4.6 million uninsured women of reproductive age.³ As of 2016, 16 percent of uninsured women of reproductive age were low-income women who lived in nonexpansion states and were ineligible for Medicaid benefits.⁴ Further, the 2016 uninsurance rate for women of reproductive age was twice as high in nonexpansion states (16.8 percent) as in expansion states (8.4 percent).⁴

What Are the Funding Options for Medicaid Expansion?

Medicaid through the ACA expansion is jointly funded by the federal government and states. In states that have expanded Medicaid, the federal government pays 90 percent of the total costs, as of 2020.⁵

Why Should Medicaid Expansion Be Expected to Impact the Prenatal-to-3 Period?

Expanding income eligibility for health insurance through state expansions of Medicaid can lead to better health and financial outcomes for those covered by the expansion.^{vi} Making more people eligible for health insurance may increase the number of people enrolled in coverage, and research has shown that health insurance coverage is associated with increased health care use.⁶ Specific to the prenatal period, expanding income eligibility for health insurance may improve birth outcomes. Before Medicaid expansion, low-income women without children had more limited access to family planning services, preventative care before conception, and prenatal care in the earliest stages of pregnancy. Having care during the preconception and interconception periods provides a window of opportunity for providers to assess and treat health conditions prior to pregnancy, which should lead to safer and healthier pregnancies and births, resulting in lower rates of birth complications, maternal and infant mortality, low birthweight, and preterm birth.^{8,9} Although Medicaid income eligibility guidelines are higher for those who are pregnant, differing income eligibility guidelines for nonpregnancy and pregnancy Medicaid can cause interruptions in health insurance coverage around childbirth known as perinatal churn, which can restrict access to care during the critical postpartum period.⁸ State Medicaid expansion decreases the gap in eligibility between nonpregnancy and pregnancy Medicaid, reducing the number of individuals susceptible to perinatal insurance churn compared to nonexpansion states.

Medicaid expansion may also impact the health and financial wellbeing of families whose incomes fall between the pre-ACA guideline in their state and 138 percent of the FPL. By providing free or low-cost health services to parents, these families may be less likely to be severely cost-burdened by medical costs and less likely to incur medical debt. Families who previously avoided medical care due to cost may be able to get necessary health care, improving physical and mental health outcomes, which may lead to increased likelihood of employment and greater earnings. Reduced medical financial burden may also lower family stress and free up resources for spending on other household needs.

What Impact Does Medicaid Expansion Have, and for Whom?

The research on expansions of Medicaid, both through the ACA and through earlier state expansions, is extensive and focuses on both a number of specific subgroups and on the overall population. To focus on the impact during the prenatal-to-3 period, the review of access and health outcomes presented here is limited to those outcomes relevant to the perinatal period, including perinatal insurance coverage and birth outcomes, and to those studies that focus on women who are of reproductive age or pregnant. Because of the significant impact of poverty on outcomes in early childhood,¹¹ this review also considers the impact of state expansions of Medicaid on economic security outcomes, though most of these studies have broader samples than just parents of young children. A comprehensive literature review of all studies related to the passage of the ACA is available online through other sources.¹²

^v Reproductive age is defined as ages 15 to 44; state Medicaid expansion covers adults ages 19 to 64.

^{vi} Research has also shown that the impacts of Medicaid expansion are not limited to those newly eligible, as increased outreach about Medicaid enrollment created a 'welcome mat' effect for those previously eligible but not enrolled.⁷

The research discussed here meets our standards of evidence for being methodologically strong and allowing for causal inference, unless otherwise noted. Each strong causal study reviewed has been assigned a letter, and a complete list of causal studies can be found at the end of this review, along with more details about our standards of evidence and review method. The findings from each strong causal study reviewed align with one of our eight policy goals from Table 1. The Evidence of Effectiveness table below displays the findings associated with state expansions of Medicaid (beneficial, null,^{vii} or detrimental) for each of the strong studies (A through W) in the causal studies reference list, as well as our conclusions about the overall impact on each studied policy goal. The assessment of the overall impact for each studied policy goal weighs the timing of publication and relative strength of each study, as well as the size and direction of all measured indicators.

Table 3: Evidence of Effectiveness for Medicaid Expansion by Policy Goal

Policy Goal	Indicator	Beneficial Impacts	Null Impacts	Detrimental Impacts	Overall Impact on Goal
Access to Needed Services	Perinatal Medicaid Coverage	B, E, D			Mostly Positive
	Overall Perinatal Uninsurance Rates	C, H	B, E		
	Postpartum Medicaid Coverage	I			
	Receipt of Recommended Prenatal Screenings	D			
	Early Prenatal Care Use		E		
	Postpartum Outpatient Care Use	I			
	Primary Care Use		C		
Sufficient Household Resources	Any Out-of-Pocket Spending on Health	F, G, M, Q			Positive
	Real Health Spending		S		
	Medical Debt	F, G, R	N		
	New Medical Collections	N			
	Catastrophic Medical Expenditures	F			
	Problems Paying Medical Bills	K, L			
	Nonmedical Debt		G		
	Cost Barriers to Care	C, K, H			
	Delinquency/Bankruptcy	R	G		
	Credit Score	N			
	Number of Loans	O			
	Amount Borrowed	O			
	Evictions	P, T			
	Total Housing/Food Spending		S		

^{vii} An impact is considered statistically significant if p<0.05.

Table 3: Evidence of Effectiveness for Medicaid Expansion by Policy Goal (continued)

Policy Goal	Indicator	Beneficial Impacts	Null Impacts	Detrimental Impacts	Overall Impact on Goal
Healthy and Equitable Births	Preterm Birth	A*	E		Mixed
	Birthweight	A*	E, W		
	Maternal Mortality Ratio	J			
	Infant Mortality	V*	W		
Parental Health and Emotional Wellbeing	Prenatal Vitamin Use	D			Mixed
	Clinical Health Outcomes		F		
	Self-Reported Health	G	K, L		
	Blood Pressure Medication Use	H			
	Insulin Use	H			
	Diagnosis of Chronic Disease		H		
	Health Behaviors		H		
	Mental Distress	L	H, K		
	Worry About Paying Medical Bills	K			
Optimal Child Health and Development	Neglect Rates	U			Trending [^] Positive
	Physical Abuse Rates		U		

*Beneficial for reducing racial disparities, null for overall population

[^]Trending indicates that the evidence is from fewer than two strong causal studies or multiple studies that include only one location, author, or data set.

Access to Needed Services

The link between state Medicaid expansion and access to, and use of, preconception and interconception care through greater insurance coverage is key to the theoretical connection between Medicaid expansion and improved birth outcomes and health during the perinatal period. For the scope of the current review, this link is only examined for women of reproductive age, and evidence shows mostly positive impacts on perinatal insurance coverage and mixed impacts on health care use.

One multistate quasi-experimental study of preconception insurance coverage found an 8.6 percentage point increase in Medicaid coverage in expansion states, though the rates of overall uninsurance did not change, indicating that some individuals switched from private insurance to Medicaid coverage when they became eligible.^B The same authors also conducted a national analysis with a sample of over 18 million and similarly found a 2.3 percentage point increase in Medicaid coverage during pregnancy but no significant impact on overall uninsurance rates during pregnancy.^E Two quasi-experimental studies of women of reproductive age found beneficial impacts on overall insurance coverage in Medicaid expansion states, ranging from a 9 percentage point increase in the odds of being insured^H to a 13.2 percentage point decrease in overall uninsurance rates.^C Finally, two studies of Medicaid expansion in Colorado and Ohio showed an average of 0.9 more months of Medicaid coverage postpartum^I and an 11.75 percentage point increase in Medicaid enrollment pre-pregnancy for first-time mothers,^D respectively.

Impacts of state Medicaid expansion on health care use among women of reproductive age are less conclusive. Rates of recommended prenatal screenings were 8.4 percentage points higher among first-time mothers (5.1 percentage points

higher for all other mothers) after Ohio's Medicaid expansion.^D A quasi-experimental study of Colorado's expansion similarly found a 17 percent increase in the number of outpatient visits postpartum.^I However, two national studies showed no significant impacts on primary care use^C or early prenatal care use^E among women of reproductive age.

Sufficient Household Resources

Overall, state expansions of Medicaid have been shown to have beneficial impacts on economic security outcomes, especially those related to spending on health care. Two studies of the randomized Oregon Medicaid lottery found that the lottery reduced the likelihood of having any out-of-pocket medical spending by 15.3 to 20 percentage points, reduced the likelihood of having any outstanding medical debt collections by 6.4 to 13.3 percentage points, and reduced the incidence of catastrophic medical expenditures by 4.5 percentage points.^{G,F} Similarly, a longitudinal treatment-on-the-treated study of enrollees after the ACA Medicaid expansion in Michigan found that enrolling in Medicaid was associated with a \$563 reduction in medical debt.^R A study of California's early state Medicaid expansion also found a 10.1 percentage point decrease in any out-of-pocket medical spending for those with incomes below 200 percent of the FPL.^Q Although these four studies each focus on a single geographic location, research using nationally representative data supports their findings. A 2020 study found that Medicaid expansion led to a 4.6 to 8.0 percentage point increase in the likelihood of having zero out-of-pocket expenditures for both insurance premiums and nonpremium medical spending, respectively.^M Additionally, two national quasi-experimental studies found that Medicaid expansion decreased problems paying medical bills by 7.1 to 13.6 percentage points.^{K,L} Another study with a sample of over 23 million records found a beneficial 3.3 percent reduction in the probability of having new medical bills sent to collections and a statistically insignificant beneficial impact on medical debt balances after state Medicaid expansion through the ACA.^N

Evidence also shows a beneficial impact of Medicaid expansion on the avoidance of health care due to cost barriers. One national study of parents and women of reproductive age found a 3.8 percentage point reduction in cost barriers to care.^C This finding is consistent with another national study that found a 7.4 percentage point reduction in avoiding care because of cost in the overall sample of women of reproductive age, with a larger 10.5 percentage point reduction among childless women.^H A study of the longer-term impacts of Medicaid expansion similarly found a 3.8 to 5.6 percentage point decrease in delaying needed care due to cost, with the size of the effect growing over time, leading to a widening of the gap between expansion and nonexpansion states.^K

Research has also shown that state expansions of Medicaid can impact nonmedical financial outcomes, though the findings are more mixed. One study found a small but statistically significant 0.1 percent increase in credit scores after Medicaid expansion,^N and the study of Michigan's Medicaid expansion through the ACA found an average reduction of \$763 per person in total debt sent to collections over the two-year study period.^R Another study of California's early Medicaid expansion showed an 11 percent decrease in the number of loans and a 10 percent decrease in the amount borrowed from payday storefronts after the expansion.^O However, one study of Oregon's randomized Medicaid lottery found no significant association with nonmedical debt or nonmedical financial strain outcomes captured in administrative data.^G

State expansions of Medicaid also have been shown to improve material wellbeing outcomes. A study of California's early Medicaid expansion found 24.5 fewer evictions per month in the state overall after expansion, with the effect growing to 51.5 fewer evictions in counties with higher proportions of uninsured residents prior to the ACA.^P The authors of this study also conducted a county-level analysis of nationwide evictions using Princeton Eviction Lab records and found 1.2 fewer evictions and 1.7 fewer eviction filings per 1,000 renters.^T Another national quasi-experimental study found no statistically significant impact of Medicaid expansion on total household spending on housing or food.^S

Healthy and Equitable Births

Evidence shows that although state expansions of Medicaid are not significantly associated with improved birth outcomes in the overall population, Medicaid expansions help to reduce racial disparities in preterm birth and infant mortality and to reduce both overall rates of, and racial disparities in, maternal mortality. Two quasi-experimental studies with samples of over one million births, one national and one focusing on a subset of states, found no significant differences in preterm birth, average birthweight, or infant mortality in expansion states relative to nonexpansion states.^{E,W} Two additional quasi-experimental studies similarly found a null effect on birth outcomes for the overall

sample but significant impacts for some racial groups when the sample was disaggregated. One study found that state Medicaid expansion was significantly associated with a 0.1 percentage point reduction in the incidence of very low birthweight and a 0.4 percentage point reduction in preterm birth rates among non-Hispanic Black infants compared to White infants in expansion states,^A and the second study found 52.6 fewer infant deaths per 1000 live births among Hispanic infants in Medicaid expansion states compared to Hispanic infants in nonexpansion states.^V A 2020 quasi-experimental study also found that Medicaid expansion was associated with 6.7 fewer maternal deaths overall per 100,000 live births; when disaggregated by race, the findings showed 16.3 fewer deaths among Black mothers, 6 fewer deaths among Hispanic mothers, and no significant impacts among White mothers.^I

Parental Health and Emotional Wellbeing

Evidence shows that state expansions of Medicaid have mixed impacts on physical health outcomes relevant to the perinatal period. A quasi-experimental study of Ohio's expansion found a 4.1 to 13.6 percentage point increase in use of prenatal vitamins, with effects larger among first-time mothers.^D Similarly, a study of women of reproductive age found that Medicaid expansion was associated with a 7.9 percentage point increase in the use of blood pressure medicine and an 11.4 percentage point increase in the use of insulin.^H Given the role of high blood pressure and gestational diabetes in birth outcomes and rates of maternal mortality and morbidity, these impacts are especially important during the perinatal period. However, the same study found no significant impact of Medicaid expansion on the diagnosis of chronic disease or likelihood of certain health behaviors, such as smoking or drinking. Further, evidence from the Oregon Medicaid lottery found no significant impact on clinical health outcomes,^F and two quasi-experimental studies also found null impacts on self-reported health.^{K,L}

Findings on the relationship between state expansions of Medicaid and mental health are also mixed. Whereas one study of low-income parents found a 10.9 percentage point reduction in retrospective self-reported severe psychological distress in expansion states relative to nonexpansion states,^L another study with a large sample of women of reproductive age found no significant impact.^H A study of the longer-term impacts of Medicaid expansion similarly found no significant impact on depression overall, though the study did find a 9.6 percentage point reduction in worrying about the ability to pay medical bills.^K

Optimal Child Health and Development

Little research has been conducted on the relationship between Medicaid expansion and child health and development; only one study on child maltreatment rates meets our standards of strong causal evidence. The national study using state administrative data found that Medicaid expansion was associated with 422 fewer reported cases of neglect per 100,000 children under the age of six, but no significant association was found with rates of reported physical abuse.^U Because neglect is often related to material wellbeing and medical care, it makes sense theoretically that Medicaid expansion should be more closely connected to neglect than child physical abuse.

Is There Evidence That Medicaid Expansion Reduces Disparities?^{viii}

Three studies examining birth outcomes showed greater reductions in adverse birth outcomes for non-Hispanic Black infants compared to White infants in expansion states,^A reductions in adverse birth outcomes for Hispanic infants in expansion states compared to Hispanic infants in nonexpansion states,^V and reduced maternal mortality for Black and Hispanic mothers in Medicaid expansion states compared with their counterparts in nonexpansion states.^I Improvements in insurance coverage and prenatal care were stronger for low-income women and first-time mothers.^{D,B,C}

Has the Return on Investment for Medicaid Expansion Been Studied?

Evidence included in this review shows that state expansions of Medicaid have improved financial wellbeing among low-income individuals and families, and these cost savings may be passed along to others as well. One study found a reduction in new incidences of unpaid medical bills after Medicaid expansion, suggesting improved financial outcomes for medical providers.^N This finding is in line with two studies outside the scope of this review that have found decreases

^{viii} Disparities are defined here as differential outcomes by race, ethnicity, or socioeconomic status (SES).

in uncompensated care for hospitals since the passage of the ACA.^{13,14} A comprehensive review of the return on investment for Medicaid expansion is forthcoming.

What Do We Know, and What Do We Not Know?

Research on expanded income eligibility for health insurance has largely focused on state expansions of Medicaid, both before and through the passage of the ACA, and this review has focused on outcomes related to the perinatal health and financial wellbeing of low-income individuals and families. The evidence shows that state expansions of Medicaid have positive impacts on economic security outcomes, mostly positive impacts on access to needed health services during the perinatal period and material wellbeing outcomes, and mixed impacts on parental physical and emotional wellbeing. Research also shows that Medicaid expansion can improve birth outcomes for some groups, demonstrating the potential to reduce racial disparities in adverse birth outcomes.

Future research should continue to examine the long-term impacts of state Medicaid expansions as policies are successfully implemented. Additionally, a future review will consider alternative state-level strategies to increase access to health insurance and health care for individuals and families.

Is Medicaid Expansion an Effective Policy for Improving Prenatal-to-3 Outcomes?

Expanding Medicaid eligibility to include most adults with incomes up to 138 percent of the FPL is an effective policy for increasing access to needed health care services, improving financial wellbeing, and reducing racial disparities in adverse birth outcomes.

How Does Medicaid Expansion Vary Across the States?

To date, 37 states^{ix} have expanded Medicaid coverage to most adults with incomes up to 138 percent of the FPL. In states that have not expanded Medicaid, income eligibility requirements for low-income parents vary widely, from 17 percent to 100 percent of the FPL for a family of three. With the exception of Wisconsin, childless adults residing in states that have not expanded Medicaid are not eligible for coverage through Medicaid at all. See Table 4 below for more details on state variation related to Medicaid expansion.

^{ix} State counts include the District of Columbia.

Table 4: State Variation in Medicaid Expansion

State has adopted and fully implemented the Medicaid expansion under the ACA that includes coverage for most adults with incomes up to 138% of the federal poverty level (FPL)						
State	Policy Adoption Yes/No	Income Eligibility Limits as a Percent of the Federal Poverty Level				Variation 12-Month Continuous Eligibility for Children's Medicaid
		Childless Adults	Parents	Pregnant Woman	Children	
Alabama	No	0%	18%	146%	317%	Yes
Alaska	Yes	138%	138%	205%	208%	Yes
Arizona	Yes	138%	138%	161%	205%	No
Arkansas	Yes	138%	138%	214%	216%	No
California	Yes	138%	138%	213%	266%	Yes
Colorado	Yes	138%	138%	200%	265%	Yes
Connecticut	Yes	138%	160%	263%	323%	No
Delaware	Yes	138%	138%	217%	217%	No
District of Columbia	Yes	215%	221%	324%	324%	No
Florida	No	0%	31%	196%	215%	No
Georgia	No	0%	35%	225%	252%	No
Hawaii	Yes	138%	138%	196%	313%	No
Idaho	Yes	138%	138%	138%	190%	Yes
Illinois	Yes	138%	138%	213%	318%	Yes
Indiana	Yes	138%	138%	218%	262%	No
Iowa	Yes	138%	138%	380%	380%	Yes
Kansas	No	0%	38%	171%	240%	Yes
Kentucky	Yes	138%	138%	200%	218%	No
Louisiana	Yes	138%	138%	138%	255%	Yes
Maine	Yes	138%	138%	214%	213%	Yes
Maryland	Yes	138%	138%	264%	322%	No
Massachusetts	Yes	138%	138%	205%	305%	No
Michigan	Yes	138%	138%	200%	217%	Yes
Minnesota	Yes	138%	138%	283%	288%	No
Mississippi	No	0%	26%	199%	214%	Yes
Missouri	No**	0%	21%	201%	305%	No
Montana	Yes	138%	138%	162%	266%	Yes
Nebraska	Yes*	138%	63%	199%	218%	No
Nevada	Yes	138%	138%	165%	205%	No
New Hampshire	Yes	138%	138%	201%	323%	No
New Jersey	Yes	138%	138%	199%	355%	Yes
New Mexico	Yes	138%	138%	255%	305%	Yes
New York	Yes	138%	138%	223%	405%	Yes
North Carolina	No	0%	41%	201%	216%	Yes
North Dakota	Yes	138%	138%	162%	175%	Yes
Ohio	Yes	138%	138%	205%	211%	Yes
Oklahoma	No**	0%	41%	138%	210%	No

Table 4: State Variation in Medicaid Expansion (continued)

State has adopted and fully implemented the Medicaid expansion under the ACA that includes coverage for most adults with incomes up to 138% of the federal poverty level (FPL)						
State	Policy Adoption Yes/No	Income Eligibility Limits as a Percent of the Federal Poverty Level				Variation
		Childless Adults	Parents	Pregnant Woman	Children	12-Month Continuous Eligibility for Children's Medicaid
Oregon	Yes	138%	138%	190%	305%	Yes
Pennsylvania	Yes	138%	138%	220%	319%	No
Rhode Island	Yes	138%	138%	195%	266%	No
South Carolina	No	0%	67%	199%	213%	NR
South Dakota	No	0%	48%	138%	209%	No
Tennessee	No	0%	94%	200%	255%	No
Texas	No	0%	17%	203%	206%	No
Utah	Yes	138%	138%	144%	205%	No
Vermont	Yes	138%	138%	213%	317%	No
Virginia	Yes	138%	138%	148%	205%	No
Washington	Yes	138%	138%	198%	317%	Yes
West Virginia	Yes	138%	138%	190%	305%	Yes
Wisconsin	No	100%	100%	306%	306%	No
Wyoming	No	0%	53%	159%	205%	Yes
Best State	N/A	215%	221%	380%	405%	N/A
Worst State	N/A	0%	17%	138%	175%	N/A
Median State	N/A	138%	138%	200%	255%	N/A
State Count	37	N/A	N/A	N/A	N/A	23

* As of August 5, 2020, Nebraska plans to implement Medicaid expansion on October 1, 2020 without the program provisions from the 1115 waiver.

** Indicates that the state has enacted but not yet implemented Medicaid expansion

Policy adoption status: Data as of October 1, 2020. Medicaid state plan amendments (SPAs) and Section 1115 Waivers.

Generosity and variation metrics: Data as of January 1, 2020. Henry J. Kaiser Family Foundation.

For additional source and calculation information, please refer to the Methods and Sources section of pn3policy.org.

How Did We Reach Our Conclusions?

Method of Review

This evidence review began with a broad search of all literature related to the policy and its impacts on child and family wellbeing during the prenatal-to-3 period. First, we identified and collected relevant peer-reviewed academic studies as well as research briefs, government reports, and working papers, using predefined search parameters, keywords, and trusted search engines. From this large body of work, we then singled out for more careful review those studies that endeavored to identify causal links between the policy and our outcomes of interest, taking into consideration characteristics such as the research designs put in place, the analytic methods used, and the relevance of the populations and outcomes studied. We then subjected this literature to an in-depth critique and chose only the most methodologically rigorous research to inform our conclusions about policy effectiveness. All studies considered to date for this review were released on or before March 31, 2020.

Standards of Strong Causal Evidence

When conducting a policy review, we consider only the strongest studies to be part of the evidence base for accurately assessing policy effectiveness. A strong study has a sufficiently large, representative sample, has been subjected to

methodologically rigorous analyses, and has a well-executed research design allowing for causal inference—in other words, it demonstrates that changes in the outcome of interest were likely caused by the policy being studied.

The study design considered most reliable for establishing causality is a randomized control trial (RCT), an approach in which an intervention is applied to a randomly assigned subset of people. This approach is rare in policy evaluation because policies typically affect entire populations; application of a policy only to a subset of people is ethically and logistically prohibitive under most circumstances. However, when available, randomized control trials are an integral part of a policy's evidence base and an invaluable resource for understanding policy effectiveness.

The strongest designs typically used for studying policy impacts are quasi-experimental designs (QEDs) and longitudinal studies with adequate controls for internal validity (for example, using statistical methods to ensure that the policy, rather than some other variable, is the most likely cause of any changes in the outcomes of interest). Our conclusions are informed largely by these types of studies, which employ sophisticated techniques to identify causal relationships between policies and outcomes. Rigorous meta-analyses with sufficient numbers of studies, when available, also inform our conclusions.

Studies That Meet Standards of Strong Causal Evidence

- A. Brown, C. C., Moore, J. E., Felix, H. C., Stewart, M. K., Bird, T. M., Lowery, C. L., & Tilford, J. M. (2019). Association of state Medicaid expansion status with low birth weight and preterm birth. *JAMA*, *321*(16), 1598–1609. <https://doi.org/10.1001/jama.2019.3678>
- B. Clapp, M. A., James, K. E., Kaimal, A. J., & Daw, J. R. (2018). Preconception coverage before and after the Affordable Care Act Medicaid expansions. *Obstetrics & Gynecology*, *132*(6), 1394–1400. <https://doi.org/10.1097/AOG.0000000000002972>
- C. Johnston, E. M., Strahan, A. E., Joski, P., Dunlop, A. L., & Adams, E. K. (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), 122–129. <https://doi.org/10.1016/j.whi.2017.11.005>
- D. Adams, E. K., Dunlop, A. L., Strahan, A. E., Joski, P., Applegate, M., & Sierra, E. (2018). Prepregnancy insurance and timely prenatal care for Medicaid births: Before and after the Affordable Care Act in Ohio. *Journal of Women's Health*, *28*(5), 654–664. <https://doi.org/10.1089/jwh.2017.6871>
- E. Clapp, M. A., James, K. E., Kaimal, A. J., Sommers, B. D., & Daw, J. R. (2019). Association of Medicaid expansion with coverage and access to care for pregnant women. *Obstetrics & Gynecology*, *134*(5), 1066–1074. <https://doi.org/10.1097/AOG.0000000000003501>
- F. Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., Schneider, E. C., Wright, B. J., Zaslavsky, A. M., & Finkelstein, A. N. (2013). The Oregon experiment — Effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, *368*(18), 1713–1722. <https://doi.org/10.1056/NEJMsa1212321>
- G. Finkelstein, A., Taubman, S., Wright, B., Bernstein, M., Gruber, J., Newhouse, J. P., Allen, H., Baicker, K., & Oregon Health Study Group. (2012). The Oregon health insurance experiment: Evidence from the first year. *The Quarterly Journal of Economics*, *127*(3), 1057–1106. <https://doi.org/10.1093/qje/qjs020>
- H. Margerison, C. E., MacCallum, C. L., Chen, J., Zamani-Hank, Y., & Kaestner, R. (2020). Impacts of Medicaid expansion on health among women of reproductive age. *American Journal of Preventive Medicine*, *58*(1), 1–11. <https://doi.org/10.1016/j.amepre.2019.08.019>
- I. Gordon, S. H., Sommers, B. D., Wilson, I. B., & Trivedi, A. N. (2020). Effects of Medicaid expansion on postpartum coverage and outpatient utilization. *Health Affairs*, *39*(1), 77–84. <https://doi.org/10.1377/hlthaff.2019.00547>
- J. Eliason, E. L. (2020). Adoption of Medicaid expansion is associated with lower maternal mortality. *Women's Health Issues*. <https://doi.org/10.1016/j.whi.2020.01.005>
- K. Miller, S., & Wherry, L. R. (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*, 327–333. <https://doi.org/10.1257/pandp.20191046>
- L. McMorrow, S., Gates, J. A., Long, S. K., & Kenney, G. M. (2017). Medicaid expansion increased coverage, improved affordability, and reduced psychological distress for low-income parents. *Health Affairs*, *36*(5), 808–818. <http://dx.doi.org.ezproxy.lib.utexas.edu/10.1377/hlthaff.2016.1650>
- M. Abramowitz, J. (2020). The effect of ACA state Medicaid expansions on medical out-of-pocket expenditures. *Medical Care Research and Review*, *77*(1), 19–33. <https://doi.org/10.1177/1077558718768895>
- N. Caswell, K. J., & Waidmann, T. A. (2019). The Affordable Care Act Medicaid expansions and personal finance. *Medical Care Research and Review*, *76*(5), 538–571. <https://doi.org/10.1177/1077558717725164>
- O. Allen, H., Swanson, A., Wang, J., & Gross, T. (2017). Early Medicaid expansion associated with reduced payday borrowing in California. *Health Affairs*, *36*(10), 1769–1776. <https://doi.org/10.1377/hlthaff.2017.0369>

- P. Allen, H. L., Eliason, E., Zewde, N., & Gross, T. (2019). Can Medicaid expansion prevent housing evictions? *Health Affairs*, 38(9), 1451–1457. <https://doi.org/10.1377/hlthaff.2018.05071>
- Q. Golberstein, E., Gonzales, G., & Sommers, B. D. (2015). California's early ACA expansion increased coverage and reduced out-of-pocket spending for the state's low-income population. *Health Affairs*, 34(10), 1688–1694. <https://doi.org/10.1377/hlthaff.2015.0290>
- R. Miller, S., Hu, L., Kaestner, R., Mazumder, B., & Wong, A. (2018). *The ACA Medicaid expansion in Michigan and financial health* (No. w25053). National Bureau of Economic Research. <https://doi.org/10.3386/w25053>
- S. Levy, H., Buchmueller, T., & Nikpay, S. (2019). The impact of Medicaid expansion on household consumption. *Eastern Economic Journal*, 45(1), 34–57. <https://doi.org/10.1057/s41302-018-0124-7>
- T. Zewde, N., Eliason, E., Allen, H., & Gross, T. (2019). The effects of the ACA Medicaid expansion on nationwide home evictions and eviction-court initiations: United States, 2000–2016. *American Journal of Public Health*, 109(10), 1379–1383. <https://doi.org/10.2105/AJPH.2019.305230>
- U. Brown, E. C. B., Garrison, M. M., Bao, H., Qu, P., Jenny, C., & Rowhani-Rahbar, A. (2019). Assessment of rates of child maltreatment in states with Medicaid expansion vs states without Medicaid expansion. *JAMA Network Open*, 2(6), e195529–e195529. <https://doi.org/10.1001/jamanetworkopen.2019.5529>
- V. Wiggins, A., Karaye, I. M., & Horney, J. A. (2020). Medicaid expansion and infant mortality, revisited: A difference-in-differences analysis. *Health Services Research*, 00(1-6). <https://doi.org/10.1111/1475-6773.13286>
- W. Boudreaux, M. H., Dagher, R. K., & Lorch, S. A. (2018). The association of health reform and infant health: evidence from Massachusetts. *Health Services Research*, 53(4), 2406–2425. <https://doi.org/10.1111/1475-6773.12779>

Other References

1. Kaiser Family Foundation. (2019). *Medicaid coverage rates for nonelderly by age*. <https://www.kff.org/medicaid/state-indicator/rate-by-age-3/?currentTimeframe=0>
2. Martin, J.A., Hamilton, B.E., Osterman, M.J.K., Driscoll, A.K. & Drake, P. (2018). Births: Final data from 2016. *National Vital Statistics Reports*, 67(1), 1-54. https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf
3. Kenney, G.M., Zuckerman, S., Dubay, L., Huntress, M., Lynch, V., Haley, J. & Anderson, N. (2012). *Opting in to the Medicaid Expansion under the ACA: Who are the uninsured adults who could gain coverage?* Urban Institute. <https://www.urban.org/sites/default/files/publication/25706/412630-Opting-in-to-the-Medicaid-Expansion-under-the-ACA.pdf>
4. McMorrow, S., Johnston, E.M., Steedle, R., Thomas, T.W. (2018). *Health insurance coverage for women of reproductive age, 2013-2016*. Urban Institute. https://www.urban.org/sites/default/files/publication/99534/2019.07.24_health_insurance_coverage_for_women_of_reproductive_age_2013-16_final_with_errata_v2_1.pdf
5. Hayes, S.L., Coleman, A., Collins, S.R. & Nuzum, R. (2019). *The fiscal case for Medicaid expansion*. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2019/fiscal-case-medicaid-expansion>
6. Institute of Medicine. (2002). *Care Without Coverage: Too Little, Too Late*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/10367>
7. Hudson, J. L., & Moriya, A. S. (2017). Medicaid expansion for adults had measurable “welcome mat” effects on their children. *Health Affairs*, 36(9), 1643–1651. <http://dx.doi.org.ezproxy.lib.utexas.edu/10.1377/hlthaff.2017.0347>
8. Searing, A. & Ross, D.C. (2019). *Medicaid expansion fills gaps in maternal health coverage leading to healthier mothers and babies*. Georgetown University Health Policy Institute. https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health_FINAL-1.pdf
9. Wherry, L. R. (2018). State Medicaid expansions for parents led to increased coverage and prenatal care utilization among pregnant mothers. *Health Services Research*, 53(5), 3569–3591. <https://doi.org/10.1111/1475-6773.12820>
10. Daw, J.R., Kozhimannil, K.B., & Admon, L.K. (2019). High rates of perinatal insurance churn persist after the ACA. *Health Affairs*. <https://www.healthaffairs.org/doi/10.1377/hblog20190913.387157/full/>
11. National Academies of Sciences, Engineering, and Medicine. (2019). *A roadmap to reducing child poverty*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25246>
12. Guth, M., Garfield, R., and Rudowitz, R. (2020). *The effects of Medicaid expansion under the ACA: Updated findings from a literature review*. The Henry J. Kaiser Family Foundation. <https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/>
13. Nikpay, S., Buchmueller, T., & Levy, H. (2015). Early Medicaid expansion in Connecticut stemmed the growth in hospital uncompensated care. *Health Affairs*, 34(7), 1170–1179. <https://doi.org/10.1377/hlthaff.2015.0107>
14. Blavin, F. (2016). Association between the 2014 Medicaid expansion and US hospital finances. *JAMA*, 316(14), 1475–1483. <https://doi.org/10.1001/jama.2016.14765>
15. Shonkoff, J., & Phillips, D. (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/9824>



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