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Medicaid: The Health and Economic Benefits of Expanding Eligibility

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KEY POINTS

- Medicaid is the largest U.S. health insurer payer with more than 76 million enrolled for comprehensive benefits in March 2024, or over 23 percent of the total population.
- Medicaid has evolved from a program primarily covering parents and dependent children receiving cash assistance with incomes well below the Federal Poverty Level to a program that extends eligibility to nearly every child and non-elderly adult in 40 states and the District of Columbia with incomes up to 138 percent or more of the Federal Poverty Level.
- The Biden-Harris Administration has taken many administrative actions and issued guidance to strengthen Americans' access to quality affordable health care through Medicaid.
- Medicaid is an especially important source of coverage for underserved communities, disproportionally covering Latinos, Black Americans, and American Indians and Alaska Natives. In 2022, over 31 percent of Latinos, 34 percent of Blacks and 38 percent of American Indian and Alaska Natives were enrolled in Medicaid.
- Medicaid and the Children's Health Insurance Program (CHIP) cover about half of all children and more than 40 percent of all births, including a majority of Latino, Black and American Indian/Alaska Native children and births.
- Research shows that Medicaid coverage for children has been found to enhance health not only during childhood, but also in adulthood.
- Medicaid eligibility for children has also been found to improve educational outcomes, which along with better health contributes to higher rates of employment and earnings as adults. This, in turn, generates increased tax revenues and reduced spending on public assistance programs.
- The Affordable Care Act's expansion of Medicaid also generated important health and economic benefits, including reduced mortality and improved financial well-being, for the adults newly gaining coverage.
- Medicaid expansion also provides economic benefits to health care providers and state governments.

INTRODUCTION

Established in 1965 and expanded significantly over the nearly six decades since then, Medicaid is a critical component of the U.S. health care system, providing health coverage and long term services and support to

more than 76 million Americans[a] including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities.[1] Medicaid covers more than one in five people living in the United States[2] and finances over 40 percent of all births each year.[3] Medicaid is a particularly important source of health coverage for certain populations, covering roughly eight in ten children in poverty and almost half of adults in poverty. Relative to White children and adults, Medicaid covers a higher share of Black, Hispanic, and American Indian and Alaska Native (AI/AN) children and adults.[4]

Through implementing legislation and taking administrative actions, the Biden-Harris Administration has enacted policies that support continuity of Medicaid eligibility and coverage, modernized and streamlined administrative systems, and provided incentives for states that have not expanded Medicaid under the Affordable Care Act (ACA) to increase coverage by doing so.

This Issue Brief discusses these recent policies in the context of the way that the Medicaid program has evolved in the six decades since it was established and in the context of a large body of academic research documenting the impact of Medicaid on health and economic outcomes. The brief focuses on Medicaid coverage for low-income children and non-elderly adults. The important protections that Medicaid provides for elderly and disabled Americans, including financing long term services and supports are beyond the scope of this Issue Brief.

BACKGROUND

Following 15 years of patchwork federal funding for medical expenses for certain populations, title XIX of the Social Security Amendments of 1965 established the Medicaid program as we know it today: a joint state-federal program that provides health coverage to low-income individuals. Initially, only low-income children and parents were covered, but over the past six decades, Medicaid coverage has become available to more Americans, as described further below. The federal government provides a majority of Medicaid's funding and establishes general guidelines regarding program eligibility, benefits, provider payments and care delivery. Within those guidelines, states have considerable flexibility to operate their programs. The first decision that states faced was whether and when to implement Medicaid. Twenty-six states implemented Medicaid by January 1967 and 11 more had done so by January 1968. By 1972, 49 states and the District of Columbia had implemented Medicaid. Arizona was the last state to implement Medicaid, doing so in 1982.[5]

The way that Medicaid's financing is split between the federal government and the states is determined by a state-specific matching rate, defined in statute and known as the Federal Medical Assistance Percentage (FMAP). A state's FMAP rate is based on its three-year average per capita income relative to the national average.[6] Lower income states receive a higher FMAP rate than higher income states. By statute, the FMAP must be at least 50 percent and cannot be more than 83 percent, no matter what the calculation determines. Ten states have FMAPs of 50 percent and seven states have FMAPs between 70 and 80 percent for FY 2024.[6] At different times, Congress has increased FMAPs to address economic crises. Examples include temporary FMAP increases in the Jobs and Growth Tax Relief Reconciliation Act of 2003, the American Recovery and Reinvestment Act of 2009, and the Families First Coronavirus Response Act of 2020.

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[a] Forty-eight states provided point-in-time enrollment, two states provided enrollment at any time in the month and one state did not include all non-MAGI enrollees. The 76.2 million Medicaid enrollees eligible for comprehensive benefits do not include Medicaid enrollees with limited benefits. The most common Medicaid limited benefits are emergency Medicaid, family planning-only coverage and payment assistance for Medicare Part B premiums and cost sharing for individuals who are dually eligible for Medicaid and Medicare https://www.medicaid.gov/medicaid/data-and-systems/downloads/macbis/2020-race-etncity-data-brf.pdf. The 76.2 million enrollees in Medicaid eligible for comprehensive benefits also do not include CHIP enrollees (7.1 million as of March 2024, See Endnote 10).

States are required to provide certain mandatory Medicaid benefits and have the choice of covering other optional benefits. Mandatory benefits include inpatient and outpatient hospital services, physician services, laboratory and x-ray services, federally qualified health center (FQHC) services, rural health clinic (RHC) services, family planning services, a robust set of comprehensive and preventive services (Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services) for children, home health services, nursing home services and behavioral/mental health services, among others. Optional benefits include services such as prescription drugs, home and community-based services (HCBS), case management, adult dental, physical therapy, and occupational therapy. States have discretion in scope of benefits, reimbursement rates, and choice of delivery of services such as fee-for-service or managed care.

Beneficiaries enrolled through the ACA Medicaid expansion group as described in section 1902(a)(10(A)(i)(VIII) of the Social Security Act receive their services through an alternative benefit plan (ABP). ABPs must cover the 10 Essential Health Benefits (EHB) as described in section 1302(b) of the Affordable Care Act whether the state uses an ABP for the Medicaid expansion population or for the package of services provided to individuals in other Medicaid eligibility groups. States must also meet requirements of the Mental Health Parity and Addiction Act, provide EPSDT-related services for individuals under age 21, assure non-emergency medical transportation (NEMT), include FQHC/RHC services and provide family planning services and supplies in the ABPs.

Medicaid payments to providers vary widely by state. In most states, base Medicaid payments to hospitals are lower than Medicare payments, though when supplemental payments are accounted for, payment rates for the two programs are more comparable.[7] Medicaid payment for primary care ranged from 32 percent to 110 percent of Medicare fees in 2019, with an average of 67 percent.[8] The most prevalent delivery system is managed care plans (74 percent of Medicaid beneficiaries were enrolled in managed care plans that cover comprehensive benefits in 2021[9]) but there are limited comparative studies of state managed care costs.

In addition to the general flexibility afforded by federal guidelines, states can obtain waivers of statutory requirements in order to further customize their program to achieve policy goals and best meet the needs of their residents. All states operate at least one Medicaid waiver. Important examples include section 1915(b) waivers, which allow states to deliver care using a managed care delivery system, and section 1915(c) waivers that allow the use of home and community-based services as alternatives to institutional care in hospitals, nursing homes and intermediate care facilities. Section 1115 demonstrations are generally statewide and can affect large portions of the state's Medicaid beneficiaries. Section 1115 demonstrations are negotiated between the state and the Centers for Medicare & Medicaid Services (CMS) with the aim of supporting state innovation and/or giving states flexibility in the design or improvement of their Medicaid program found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. Among other aspects, demonstrations must be budget neutral, meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration as a condition of approval. In addition, states must conduct systematic monitoring and robust evaluation of their demonstrations. Section 1115 demonstrations are generally approved for five years and then can be renewed for an additional three to five years at a time.

MEDICAID ELIGIBILITY

Initially, Medicaid eligibility was limited to "categorically needy" individuals who qualified by being enrolled in cash assistance programs—most importantly, Aid for Families with Dependent Children (AFDC)—as well as "medically needy" individuals who did not meet the categorical requirements but had sufficient medical expenses to bring their income after medical expenses below the income eligibility threshold that applied to those other programs.

Eligibility remained quite limited through the 1970s. Legislation enacted in the 1980s and 1990s expanded eligibility, breaking the link between Medicaid and AFDC and raising income eligibility standards. These expansions progressed incrementally, first targeting pregnant women, infants and younger children, and then people age 65 and over, and people with blindness and disabilities. The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP, later referred to as CHIP) allowing states to cover uninsured children with family incomes up to 200 percent FPL who were not eligible for Medicaid in their state with FMAPs at a higher rate than regular Medicaid. The Children's Health Insurance Reauthorization Act of 2009 expanded CHIP to cover pregnant women. CHIP is not an entitlement program and needs appropriated funding. States may administer CHIP programs separate from Medicaid, use CHIP funding for expanding Medicaid or have a combination program (separate CHIP and expanded Medicaid eligibility for children). Separate CHIP programs may have fewer benefits and higher cost-sharing for services as they do not have to comply with Medicaid's guaranteed children's benefit (EPSDT) or cost-sharing protections for children. There were 7.1 million CHIP enrollees in March 2024.[10] As of March 2023, nearly 42 million children were enrolled in Medicaid and CHIP, providing health coverage to more than half of all children.[11]

By 2010, federal policy had established minimum income eligibility standards of 133 percent of the FPL for children under age 6 and 100 percent of FPL for children between the ages of 6 and 18. However, in nearly every state, the income eligibility limit for children was substantially higher: in 45 states and the District of Columbia, the eligibility limit for Medicaid or CHIP was at or above 200 percent of FPL in January 2012.[12] In contrast, Medicaid income eligibility limits for parents were generally much lower. In January 2012, 17 state Medicaid programs had income limits for parents at less than 50 percent of the FPL, 16 states had income limits for parents with incomes between 50 and 99 percent of the FPL, and 18 states and the District of Columbia had income limits for parents with incomes at 100 percent of the FPL or greater.[13] Coverage options were even more limited for non-disabled adults without children. In January 2012, 26 states provided no coverage, 4 states provided only premium assistance, 13 states provided coverage that was more limited than Medicaid, and 7 states and the District of Columbia provided coverage that was comparable to Medicaid.

State Medicaid eligibility rules have also historically included asset limits. Countable assets include cash, bank balances, stocks and bonds. States often have disregards or exempt personal property such as primary residence, personal vehicle, burial insurance, preplanned funeral agreements, jewelry, home furnishings, and clothes from the asset limits. Between 1996 and 2011, 24 states eliminated their Medicaid asset limits for families (but not for individuals who were Medicaid eligible as aged, blind, or disabled)[14], which were typically $1000 to $3000 per individual.[15]

THE ACA MEDICAID EXPANSION

Medicaid expansion was a key pillar of the ACA, expanding Medicaid to eligible adults with incomes below 138 percent of FPL.[b] The Medicaid expansion was to go into effect in January 2014, at the same time as the ACA's private insurance market provisions. The ACA included both carrots and sticks to encourage states to expand their Medicaid programs. The carrot was a higher FMAP for individuals enrolled through the expansion than what states receive for their other Medicaid enrollees. The federal government covered 100 percent of the cost of expansion for the first three years, tapering down to 90 percent by 2020 and subsequent years. The stick was that states that did not expand would lose federal matching for their existing Medicaid programs. In 2012, in the case of National Federation of Independent Business v. Sebelius, the Supreme Court ruled that this penalty for not expanding was coercive and unconstitutional, essentially making expansion a state option. CMS

[b] Technically, the income eligibility limit for the ACA Medicaid expansion is 133 percent of FPL with a 5 percent disregard.

issued guidance that there was no deadline for states to decide when to implement Medicaid expansion, and that the enhanced FMAP was only available for full Medicaid.[16]

Seven states took advantage of a provision in the law allowing them to begin the expansion before 2014, although some of these states had limited expansion programs lower than 133 percent FPL.[17,18] Including those seven states, 25 states and the District of Columbia implemented Medicaid expansion on January 1, 2014. Other states implemented the expansion in later years, as shown in Table 1. A total of 22.5 million were Medicaid expansion enrollees in September 2023.[19]

Table 1. ACA Medicaid Implementation Date by State

Implementation Date	States		
April 2010 to April 2012	California Colorado New Jersey	District of Columbia Minnesota	Washington Connecticut
January 1, 2014	Arizona Arkansas Delaware Hawaii Illinois Iowa Kentucky	Maryland Massachusetts Nebraska Nevada New Mexico New York North Dakota	Ohio Oregon Rhode Island Vermont West Virginia
2014, after January	Michigan	New Hampshire	
2015	Pennsylvania	Indiana	Alaska
2016	Montana	Louisiana	
2018	Maine		
2019	Virginia		
2020	Idaho	Utah	
2021	Oklahoma	Missouri	
2023	South Dakota	North Carolina	

In addition to increasing income eligibility limits, the ACA modernized enrollment and eligibility systems and processes, making it easier for eligible individuals to obtain and maintain coverage. The law replaced complex rules for counting income with a new methodology, Modified Adjusted Gross Income (MAGI) and eliminated the Medicaid asset limit, which now applies to most eligibility categories.[20] The non-MAGI Medicaid enrollees eligible as disabled or aged still have state eligibility limits on income and assets. Lower-income Medicaid enrollees who have the limited benefit of Medicaid paying for part or all of Medicare Part B premiums and cost sharing have federal eligibility limits on income and assets.[21] These simpler rules, along with system changes decreased burden for applicants and created administrative efficiencies for states.

BIDEN-HARRIS ADMINISTRATION MEDICAID POLICIES

Medicaid has been an important priority for the Biden-Harris Administration from day one. in January 2021, the Administration issued Executive Order 14009, *Strengthening Medicaid and the Affordable Care Act,* which directed the Department of Health and Human Services (HHS) to review and consider suspending, revising or rescinding waivers, demonstrations and other policies that present unnecessary barriers to accessing Medicaid

or otherwise undermine the program.[22,23] In April 2022, the Administration reaffirmed its goals with respect to health coverage with Executive Order 14070, *Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage.*[23] Table 2 presents a summary of the Administration's Medicaid policies.

Table 2: Biden-Harris Administration Policies on Medicaid

Policy	Actions
Strengthening Medicaid and the Affordable Care Act Executive Order 14009 January 2021	Directs HHS to review and consider suspending, revising or rescinding waivers, demonstrations or other policies that present unnecessary barriers to accessing Medicaid or otherwise undermine the program
CMS guidance on social determinants of health January 2021	State options on housing, nutritional, transportation, safe neighborhoods, social connections, education, job training, and other services
American Rescue Plan March 2021	Temporary 5 percentage point increase in FMAP for states adopting the ACA Medicaid expansion Temporary 10 percentage point increase in state FMAPs for certain home and community-based services State option for 12 months of postpartum coverage
Consolidated Appropriations Act December 2022	States required to provide 12 months of continuous eligibility for children in Medicaid and CHIP
Medicaid Unwinding March 2023	Simplified eligibility requirements Streamlined application processes such as auto-renewal State operational system improvements
Medicaid Reentry Section 1115 Demonstrations April 2023	Services for incarcerated individuals prior to their release
CMS guidance on Medicaid services in school-based settings May 2023	Flexibilities on provider enrollment Flexibilities for states to bill Medicaid
Streamlining Medicaid, CHIP and Basic Health Program Application, Eligibility Determination, Enrollment and Renewal Processes Final Rule March 2024	Simplified eligibility requirements Streamlined application processes such as auto-renewal State operational system improvements

The Biden-Harris Administration has partnered with states to strengthen Medicaid and CHIP. The American Rescue Plan of 2021 (ARP) provided qualifying states with a temporary 10 percentage point increase in their FMAP for certain home and community-based services (HCBS).[24] This increased funding allowed states to address HCBS workforce challenges and expand capacity for providing critical services that allow millions of Medicaid beneficiaries to receive services in their own home or community rather than in institutions. The law provided a temporary 5 percentage point increase in Medicaid federal matching funds for states adopting the ACA Medicaid expansion. The four most recent states to adopt the expansion—Oklahoma, Missouri, South Dakota and North Carolina—have benefited from this policy. It is estimated that these four states received $3.5 billion over two years.[25]

The ARP also allowed states to provide 12 months of postpartum coverage, an option that was made permanent by the Consolidated Appropriations Act, 2023 (CAA, 2023).[c] As of July 2024, 46 states, the District of Columbia, and the U.S. Virgin Islands have implemented this option, resulting in an estimated 694,000 individuals gaining additional months of postpartum Medicaid coverage.[26,27] If the remaining four states were to adopt this policy, an additional 720,000 people would have 12 months of postpartum coverage each year. Research indicates that, prior to postpartum extension, more than 20 percent of women with pregnancy-related Medicaid coverage became uninsured within six months after giving birth – and that in non-expansion states, this rate was nearly twice as high.[27] With roughly half of pregnancy-related deaths occurring between one week and one year after childbirth, postpartum insurance coverage is vital to reducing maternal morbidity and mortality.[28]

The CAA, 2023 also required states to provide 12 months of continuous eligibility for children enrolled in Medicaid and CHIP beginning on January 1, 2024. While children have long been less likely to be uninsured than adults, short-term changes in household size or income may cause a gap in their Medicaid or CHIP coverage.[29,30] Gaps in coverage are associated with increased risk of unmet health needs, delayed care, lower vaccination coverage, unfilled prescriptions, and increased asthma-related emergency department visits. Under the continuous eligibility requirement, more than 17 million Medicaid and CHIP-eligible children will potentially benefit from the change.[31]

CMS has approved section 1115 demonstration authority to allow states to go above and beyond the 12-month continuous eligibility requirement to provide multi-year continuous eligibility. Three states—New Mexico, Oregon, and Washington—have received CMS approval to go even further by providing continuous eligibility for children ages 0-6 and several other states have submitted demonstration applications for multi-year continuous eligibility.[11]

Other section 1115 demonstrations that have been approved by the Biden-Harris Administration are aimed at improving coverage among specific vulnerable populations. For example, the Medicaid Reentry Section 1115 Demonstration Opportunity, which has been approved in California, Montana, Washington, Massachusetts, Kentucky, Oregon, Utah, Vermont, Illinois, New Hampshire, and New Mexico allows state Medicaid programs to cover pre-release services for eligible incarcerated individuals in the period immediately prior to their release, with the goal of the demonstration to provide medical assistance and improve the health of communities and populations.[32,33] The pre-release benefit package is designed to improve care transitions of such individuals back to the community, including by promoting continuity of coverage, service receipt, and quality of care, as well as the proactive identification of both physical and behavioral health needs.

Medicaid covers low-income populations, which are affected more by social determinants of health than the general population, including low education levels, transportation needs, violence in the home and

[c] States with a separate CHIP that elect to extend postpartum coverage in Medicaid must also extend coverage in their separate CHIP.

community, housing quality and instability, and food insecurity.[34] In January 2021, CMS issued guidance to states on opportunities in Medicaid and CHIP to address social determinants of health under state plan authority (SPA), section 1115 demonstrations, and managed care plans.[35] CMS also issued guidance to states on the use of "in lieu of" services or settings which are medically appropriate and cost effective substitutes for state plan covered Medicaid benefits, such as nutrition supports in January 2023.[36] In November 2023, guidance was issued on opportunities to cover clinically appropriate and evidence-based services and supports that address health-related social needs (HRSN).[37] To date, CMS has approved section 1115 demonstrations that align with the recently released HRSN framework in ten states to cover certain "in lieu of" services. State services include asthmatic remediation, sobering centers, caregiver respite, medically tailored meals, home modifications, housing deposits, cochlear implants, and mobile crisis outreach teams.[38]

Final rules recently released by CMS seek to strengthen Americans' access to affordable quality health through Medicaid. The *Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes* final rule, released in March 2024, builds upon the significant eligibility and enrollment changes needed to implement the ACA by further simplifying eligibility requirements and streamlining application processes to eliminate unnecessary barriers to enrollment. The *Ensuring Access to Medicaid Services* final rule, released in April 2024, advances quality of care for Medicaid enrollees by increasing transparency and accountability, standardizing data and monitoring, and creating opportunities for states to actively engage beneficiaries in their Medicaid programs.[39] The rule requires states to publish Medicaid payment rates on a publicly accessible website, to conduct and publish analyses comparing those rates to Medicare rates, and establishes new standards for and strengthens oversight of HCBS programs.

The *Medicaid and Children's Health Insurance Program Managed Care Access, Finance*, and Quality final rule, also released in April 2024, strengthens standards for timely access to care and states' monitoring and enforcement efforts and establishes a quality rating system for Medicaid and CHIP managed care plans. Secret shopper surveys on appointment availability within specified maximums by service and on accuracy of provider directories are required starting with the rating period for Medicaid managed care contracts beginning July 10, 2028.

In addition, as required by the Bipartisan Safer Communities Act (BSCA), CMS released new guidance on delivering Medicaid services in school-based settings.[40] School-based services have been associated with improved health outcomes, including improvements in vaccination rates and the use of preventive services, and education outcomes, such as grade point average and grade promotion.[41,42]

The Families First Coronavirus Response Act of 2020 (FFCRA) provided states with a temporary increase in their FMAP in return for agreeing to not disenroll people from Medicaid during the COVID-19 Public Health Emergency. This continuous eligibility condition ended on March 31, 2023, and states began returning to normal Medicaid renewal operations, a process referred to as "Medicaid unwinding." CMS has worked with states to mitigate coverage loss by supporting strategies to streamline processes and help eligible people renew their coverage.[43] CMS also has supported state operational and system improvements. For example, CMS partnered with the US Digital Service and states to address system problems, reduce red tape and to increase the number of renewals that can be done based on data available to the state (called *ex parte* renewals).[44] One indication of the success of these efforts is that *ex parte* renewal rates nearly doubled between April and December 2023.[45] Another positive indicator is that by the fourth quarter of 2023, roughly nine months after the start of the unwinding, the uninsured rate was 7.7 percent, a historically low level.[46]

RESEARCH ON THE BENEFITS OF MEDICAID

There is a large research literature on the impact of Medicaid on a wide range of health and economic outcomes.[47] Several studies exploit the variation arising from the way Medicaid was initially implemented starting in 1965. One study leverages the program's staggered adoption across the states to compare adult health outcomes of individuals who differed in their exposure to Medicaid as children. The results indicate that greater exposure to Medicaid eligibility is associated with a significant improvement in health as measured by a composite index that combines information on high blood pressure, diabetes, heart disease, and obesity.[48] Another study uses variation in the timing of initial Medicaid adoption to examine the program's impact on mortality, finding that exposure to Medicaid is associated with significantly lower mortality in both childhood and adulthood.[49] Because Medicaid eligibility was initially linked to enrollment in AFDC, the initial adoption of Medicaid led to greater increases in coverage in states with larger AFDC programs. Two recent studies exploit this variation to examine short- and long-run impacts of the introduction of Medicaid.[50,51] The first study uses this variation to estimate effects on mortality for infants and children in the short run; the second estimates longer run effects on mortality for those same children in later life. Both studies find significant reductions in mortality as a result of Medicaid.

Many studies examine the effect of Medicaid eligibility expansions for pregnant women and children in the 1980s and early 1990s. This literature finds strong evidence that these expansions increased the utilization of important health care services, leading to immediate and long-run improvements in health. Eligibility expansions for pregnant women led to earlier initiation of prenatal care and reductions in low birthweight and infant mortality.[52,53,54,55] Eligibility expansions for children were associated with significant increases the probability that children have an annual "well child" physician visit and important preventive care, such as vaccinations.[56,57,58,59,60] One study finds that the expansion of Medicaid eligibility for children between 1984 and 1992 led to a 5 percent reduction in child mortality.[56]

The access to preventive care that insurance coverage affords also has the potential to affect long-run health outcomes. Several studies find that children who were eligible for Medicaid, or whose mothers gained eligibility when they were pregnant, were in better health as older children and young adults.[59,61,62,63] These health improvements translate to lower mortality. One study finds that significant reductions in teenage mortality among Black children who gained access to Medicaid as young children compared to slightly older children who had less access to Medicaid.[64] Another found that an additional year of Medicaid eligibility before age 18 reduces cumulative mortality between the age of 19 and 28 by 2.5 percent.[65]

Healthier children can be expected to do better in school because they are able to concentrate better and because they miss fewer days due to illness. By improving child health and providing opportunities to diagnosis conditions that may affect learning, Medicaid can affect educational outcomes. Several studies find evidence of such effects. Medicaid eligibility expansions have been found to increase test scores and reduce the probability that a child is below grade level.[66,67] Medicaid eligibility has also been found to increase high school and college completion.[62,65,68] Higher levels of education and better health contribute to better labor market outcomes. Studies find that eligibility for Medicaid early in life leads to higher rates of employment, higher earnings, lower rates of disability and lower rates of public assistance receipt.[51,65] One study found that access to Medicaid as a young child decreases the likelihood of being incarcerated by age 28. This effect was driven mainly by a decrease in financially motivated offenses.[69]

Finally, a recent study indicates that these children not only grow up into healthier and more economically secure adults, but that these benefits may extend to the next generation of children. Mothers who gained Medicaid during early childhood themselves were found to give birth to healthier children when they started their own families.[55]

A large body of research documents the impact of the ACA Medicaid expansion on a broad range of health and economic outcomes.[70] Numerous studies find that Medicaid expansion led to significant improvements in rates of self-reported access to and utilization of care, including primary and preventive care, mental health care, emergency care and prescription drugs.[71,72,73] In states that expanded Medicaid, there was a reduction in the number of adults saying that they went without care because of cost or that they had trouble paying medical bills.[74]

Other research finds that this increase in utilization translated to improved health outcomes. Studies have linked insurance expansions under the ACA to increases in early-stage cancer diagnosis, which is associated with better cancer outcomes; improved blood pressure and glucose control; and reductions in the probability of pre-term birth.[75,76] Importantly, there is strong evidence that the ACA Medicaid expansion led to meaningful declines in mortality. One important study uses individual-level data from the Census Bureau's American Community Survey linked to administrative Medicaid enrollment data and death records to estimate the effect of the ACA Medicaid expansion on mortality.[77] The study uses a difference-in-differences research design that compares low-income adults in expansion states to similar individuals in non-expansion states after the ACA coverage provisions went into effect. They find that Medicaid expansion reduced mortality by 9 percent relative to the baseline over the first four years after expansion. Their main results imply that if all states had adopted the Medicaid expansion in 2014, over 15,000 deaths would have been avoided between 2014 and 2017. Other studies using different data find similar results.[78,79]

In addition to these positive health effects, the ACA Medicaid expansion produced substantial financial benefits to low-income Americans.[80] Medicaid expansion led to reductions in unpaid bills and medical debt, which translated to improved credit scores and reduced rates of bankruptcy. Medicaid expansion is associated with a reduction in the use of payday loans and a decline in home evictions.[81,82,83,84,85] A study of 5 million credit reports found that medical debt decreased by 12 percent in Medicaid expansion states compared to a decrease of 1 percent in non-expansion states.[86] Medicaid enrollees had lower medical debt of $3.4 billion in the first two years and better credit terms worth $520 million per year.[87] It is estimated that half the decrease in Chapter 7 bankruptcy rates from 2014-2018 is attributed to people gaining Medicaid expansion coverage.[88] The results from these ACA studies align with research finding that earlier Medicaid expansions generated important financial benefits, including declines in the probability of having bills sent to collection agencies, improved credit-risk scores and reduced rates of personal bankruptcy.[89,90,91]

The financial protection that Medicaid provides to low-income patients generates benefits for health care providers as well. In 2012, prior to the ACA coverage expansions, hospitals in the U.S. provided over $46 billion in uncompensated care.[92] After 2014, hospital uncompensated care expenditures fell significantly in Medicaid expansion states, though not in non-expansion states.[93,94] The greatest improvements in hospital financial performance were seen in states where the ACA Medicaid expansion had larger effects on Medicaid eligibility.[95] The ACA Medicaid expansion was associated with lower rates of hospital closure, especially in rural areas and areas with high rates of uninsurance prior to the ACA.[96,97]

A comprehensive evaluation of over 100 historical tax and expenditure policies uses estimates of causal effects drawn from published research (including several of the studies mentioned above) to assess the benefits that each policy provides to recipients and the cost to the government.[98] The cost calculation accounts not only for direct program expenditures but also long-run effects on the government's budget, e.g., effects of other program spending or tax revenues. The evaluation finds that the long-run benefits of expanding Medicaid eligibility to pregnant women and children described above—lower Medicaid and uncompensated care expenditures due to improved adult health, lower transfer program payments, and greater tax revenues due to higher earnings—were substantially larger than the direct cost of providing coverage. Considering several different Medicaid expansions together, the analysis indicates that each dollar spent on expanding Medicaid

for children repaid roughly $1.80 to the government in the long run. The Congressional Budget Office estimates that long-term fiscal effects (higher income and tax revenues) of Medicaid spending on children can offset half or more of the initial Medicaid spending.[99]

LOOKING FORWARD: ADDITIONAL OPPORTUNITIES TO REALIZE THE BENEFITS OF MEDICAID

It is estimated that if the 10 states that have not adopted the ACA Medicaid expansion (Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming) were to do so, the number of uninsured would fall by 2.3 million.[100] More than half of those who would gain coverage are Black or Latino.

The extensive research just described indicates that expansion provides significant health and economic benefits to the newly insured. Polling data suggests that the American public is aware of and appreciates those benefits. Two-thirds of American adults say that themselves or their family members of close friends have direct experience with Medicaid. Over three-quarters of Americans have a favorable view of Medicaid and two-thirds of adults in non-expansion states think their states should expand the program.[101] In six states, Medicaid expansion was passed through a ballot initiative.[102]

One argument that is sometimes made against Medicaid expansion is that even with the Federal government covering 90 percent of the cost, expansion is too costly. This argument does not account for the full fiscal impact of Medicaid expansion, which includes both budget offsets and increased revenues. Expanded Medicaid coverage offsets some of the cost of existing state health programs, such as ones providing behavioral health care to uninsured individuals or health care services to incarcerated populations.[103] In addition, Medicaid expansion increases state tax revenues in two ways. First, in most states part of the funding for Medicaid comes from taxes on health care providers. Even if those tax rates remain constant, the increased payments to providers caused by Medicaid expansion will lead to increased tax revenues. And some states have increased provider taxes to cover more of the cost of expansion. Second, the large inflow of federal spending that comes with expansion acts as a fiscal stimulus that increases state tax revenues more generally by increasing economic activity in the state.

In Michigan, the legislation that established the Healthy Michigan Plan, the states' version of the ACA Medicaid expansion, included a provision that the program would automatically sunset if the anticipating savings did not cover the state's share of the cost of expansion. As a result, the fiscal impact of the Healthy Michigan Plan has been closely monitored. In 2018, Michigan's House Fiscal Agency concluded that since it was established in 2014, the program had generated annual fiscal savings of over $200 million and would continue to generate savings over the next decade.[104] This analysis does not include the increase in tax revenues generated by expansion, which were projected to be larger than the fiscal offsets.[105]

There have been several other state-specific studies on the fiscal impact of Medicaid expansion.[106,107,108,109,110,111] Although the details vary across states, a common finding is that between cost offsets and increased tax revenue, Medicaid expansion more than paid for itself. These studies are generally prospective, projecting expenditures for Medicaid and other programs based on assumptions about enrollment and other key factors. Research examining the actual experience of states that expanded Medicaid supports these projections. One study found that while the growth in Medicaid spending was 24 percent higher in expansion states than non-expansion states between 2010 and 2018, federal funding was sufficient to cover this differential. The study found no effect of Medicaid expansion on state spending on other priorities.[112]

As noted, a provision of the ARP makes the fiscal argument for expanding even more compelling. The law offers states that have not yet expanded a temporary (2 year) FMAP increase of 5 percentage points to be applied to the cost of covering non-expansion beneficiaries. One analysis concluded that this funding alone would be sufficient to fully cover the non-federal portion of expansion costs for between 3 and 6.5 years, depending on the state.[113]

Other state actions can help people who gain Medicaid coverage remain enrolled. As noted, as a result of the ARP and CAA, 2023, states may guarantee 12 months of postpartum coverage for pregnant women. Three of the four states that have not yet implemented this policy have active proposals to do so. Given that Medicaid covers more than 40 percent of all births in the U.S., Medicaid coverage during the postpartum period is an important policy tool for improving maternal health. All states have implemented 12-month continuous eligibility for children and several states have sought waivers to provide multiple years of continuous eligibility. These policies can be expected to improve continuity of care by reducing administrative "churn."

During the Medicaid unwinding, CMS approved more than 400 temporary waivers for state strategies for streamlining renewal processes to ensure that eligible beneficiaries can retain coverage.[43] Some of these strategies aim to increase *ex parte* renewal rates based on data from other programs. States' experiences with these new approaches will provide valuable evidence on best practices. Making successful strategies permanent will lead to further progress in reducing burden for beneficiaries and administrative costs for states and improving continuity of coverage.

CONCLUSIONS

Since it was established in 1965, Medicaid has grown from a small program serving children and parents with very low incomes, to become a critical component of the U.S. health care system, covering more than one fifth of all Americans and nearly 40 percent of children. Providing comprehensive benefits with minimal out-of-pocket costs, Medicaid ensures access to necessary health care services that beneficiaries would otherwise not be able to afford. A large body of research indicates that this access to care delivers significant health benefits. Medicaid coverage for children has been shown to produce immediate and long-term improvements in health and greater economic success. The expansion of Medicaid eligibility under the ACA led to similar benefits for adults, including a significant reduction in mortality and meaningful improvements in financial well-being. If the ten states that have not yet implemented the ACA Medicaid expansion were to do so, millions of Americans would gain coverage, with little or no cost to the states.

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