

The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review

Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Madeline Guth

A substantial body of research has investigated effects of the Medicaid expansion under the Affordable Care Act (ACA) on coverage; access to care and related measures (including utilization, quality of care and health outcomes, provider capacity, and affordability and financial security); and various economic measures. This issue brief summarizes findings from 324 studies of the impact of state Medicaid expansions under the ACA published beginning in January 2014 (when the coverage provisions of the ACA went into effect) and updates earlier versions of this brief with studies through June 2019.¹ More recent studies continue to support earlier findings but provide additional findings in key areas, including expansion's effects on health outcomes, access to services and medications for behavioral health – including opioid use disorder -- and other needs, providers' financial stability, and employment and the labor market.

Key Findings

Research indicates that the expansion is linked to gains in coverage; improvements in access, financial security, and some measures of health status/outcomes; and economic benefits for states and providers.

- **Coverage:** Studies show that Medicaid expansion states experienced significant coverage gains and reductions in uninsured rates among the low-income population broadly and within specific vulnerable populations. States that implemented the expansion with a waiver have seen coverage gains, but some waiver provisions appear to compromise coverage.
- **Access to care and related measures:** Most research demonstrates that Medicaid expansion has improved access to care, utilization of services, the affordability of care, and financial security among the low-income population. Studies show improved self-reported health following expansion and an association between expansion and certain positive health outcomes. A small subset of study findings showed no effects of expansion on certain specific measures within these access-related categories. Findings on expansion's effect on provider capacity are mixed, with studies showing increases, decreases, or no effects on measures like appointment availability or wait times.
- **Economic measures:** Analyses find effects of expansion on numerous economic outcomes, including state budget savings, revenue gains, and overall economic growth. Multiple studies suggest that expansion can result in state savings by offsetting state costs in other areas. The federal government covered 100% of the cost of the expansion in the early years of the ACA, and will cover 90% over time. There is limited research examining the fiscal effects of the Medicaid expansion at the federal level. Additional studies show that Medicaid expansions result in reductions in uncompensated care costs for hospitals and clinics, and a growing number of studies show an association between expansion and gains in employment as well as growth in the labor market (with a minority of studies showing neutral effects in this area).

This literature review includes studies, analyses, and reports published by government, research, and policy organizations using data from 2014 or later. This brief only includes studies that examine impacts of the Medicaid expansion in expansion states. It excludes studies on impacts of ACA coverage expansions generally (not specific to Medicaid expansion alone), studies investigating potential effects of expansion in states that have not (or had not, at the time of the study) expanded Medicaid, and reports from advocacy organizations and media sources. Findings are separated into three broad categories: Medicaid expansion's impact on coverage; access to care and related measures (including utilization, quality of care and health outcomes, provider capacity, and affordability and financial security); and economic outcomes for the expansion states. The Appendix at the end of the brief provides a list of citations for each of the included studies, grouped by the three categories of findings.

Recently published studies from late 2018 through June 2019 support earlier findings while using the additional years of experience with expansion to deepen findings in many areas, including expansion's effects on health outcomes, access to services and medications for behavioral health and other needs, providers' financial stability, and employment. Among other findings, new studies in these areas show that expansion is associated with increases in cancer diagnosis rates (especially early-stage diagnosis rates) and access to and utilization of certain types of cancer surgery; increases in access to and Medicaid coverage of treatment (including medication assisted treatment) for opioid use disorder and opioid overdose; a reduction in the US poverty rate; and improvements in employment and the labor market. Recently published studies in many areas have looked at more narrow population groups (e.g., individuals with a specific disease diagnosis or patients hospitalized for a specific condition).

We will continue to monitor and update these findings as additional studies and state experiences provide insight into how various factors shape coverage, access to care, and costs in Medicaid expansion states and as states continue to consider expansion and reshape Medicaid coverage. Multiple recent policy changes, including the repeal of the ACA's individual mandate penalty, shifting immigration policies including proposed "public charge" policies, and new [waiver provisions recently approved by or pending approval](#) from the Trump administration, may have implications for the effects of expansion demonstrated in studies to date. In addition, the effect of expansion on state budgets could change as states have to shoulder an increased share of the cost. Future research can help policymakers better understand how these policy shifts affect state experiences with Medicaid expansion.

Impacts on Coverage

Uninsured Rate and Medicaid Coverage Changes

States expanding their Medicaid programs under the ACA have seen large increases in Medicaid enrollment. These increases have been driven by enrollment of adults made newly eligible for Medicaid under expansion. Enrollment growth also occurred among both adults and children who were previously eligible for but not enrolled in Medicaid (known as the "woodwork" or "welcome mat" effect). Recent research found that Medicaid coverage gains occurred even in some states that had relatively generous Medicaid eligibility levels prior to the ACA, either among the low income population broadly or among certain specific population groups. Some, but not all, research finds evidence of reduced coverage churn

in expansion compared to non-expansion

states.²³⁴⁵⁶⁷⁸⁹¹⁰¹¹¹²¹³¹⁴¹⁵¹⁶¹⁷¹⁸¹⁹²⁰²¹²²²³²⁴²⁵²⁶²⁷²⁸²⁹³⁰³¹³²³³³⁴³⁵³⁶³⁷³⁸³⁹

Numerous analyses demonstrate that Medicaid expansion states experienced large reductions in uninsured rates that significantly exceed those in non-expansion states. Declines began in 2014, and some studies showed that expansion-related enrollment growth in Medicaid and declines in uninsured rates in expansion states continued in 2015, 2016, and 2017 and that the gap between coverage rates in expansion and non-expansion states continued to widen in the years after 2014. The sharp declines in uninsured rates among the low-income population in expansion states are widely attributed to gains in Medicaid

coverage.⁴⁰⁴¹⁴²⁴³⁴⁴⁴⁵⁴⁶⁴⁷⁴⁸⁴⁹⁵⁰⁵¹⁵²⁵³⁵⁴⁵⁵⁵⁶⁵⁷⁵⁸⁵⁹⁶⁰⁶¹⁶²⁶³⁶⁴⁶⁵⁶⁶⁶⁷⁶⁸⁶⁹⁷⁰⁷¹⁷²⁷³⁷⁴⁷⁵⁷⁶⁷⁷⁷⁸⁷⁹⁸⁰⁸¹⁸²⁸³⁸⁴⁸⁵⁸⁶⁸⁷⁸⁸⁸⁹⁹⁰⁹¹

Several studies identified larger coverage gains in expansion versus non-expansion states for specific vulnerable populations, including young adults, prescription drug users, people with substance use disorders, people with HIV, low-income adults who screened positive for depression, cancer patients, adults with a history of cardiovascular disease or two or more cardiovascular risk factors, women diagnosed with a gynecologic malignancy, veterans, parents, mothers, women of reproductive age (with and without children), children, lesbian, gay, and bisexual adults, low-income workers, low-educated adults, justice-involved individuals, noncitizens, early retirees, and childless adults with incomes under 100% FPL. An additional study found no significant differences in coverage gains for people in mixed-status-households (those that likely include undocumented immigrant(s)) relative to non-mixed-status households in expansion states, whereas coverage gains were significantly lower for people in mixed-status relative to non-mixed-status households in non-expansion

states.⁹²⁹³⁹⁴⁹⁵⁹⁶⁹⁷⁹⁸⁹⁹¹⁰⁰¹⁰¹¹⁰²¹⁰³¹⁰⁴¹⁰⁵¹⁰⁶¹⁰⁷¹⁰⁸¹⁰⁹¹¹⁰¹¹¹¹¹²¹¹³¹¹⁴¹¹⁵¹¹⁶¹¹⁷¹¹⁸¹¹⁹¹²⁰¹²¹¹²²¹²³¹²⁴

Most analyses that looked at rural/urban coverage changes find that Medicaid expansion has had a particularly large impact on Medicaid coverage or uninsured rates in rural areas. For example, one study found that the Medicaid expansion closed the small gap in the uninsured rate among nonelderly adults living in urban vs. rural locations. Another study found that Medicaid expansion narrowed the disparity in Medicaid insurance rates between rural and urban childless adults. However, as noted below, research on coverage effects in rural versus urban areas was mixed.¹²⁵¹²⁶¹²⁷¹²⁸

Studies show larger Medicaid coverage gains and reductions in uninsured rates in expansion states compared to non-expansion states occurred across most or all of the major racial/ethnic categories. Additional research also suggests that Medicaid expansion has helped to reduce disparities in coverage by income, age, marital status, and, in some studies, race/ethnicity.¹²⁹¹³⁰¹³¹¹³²¹³³¹³⁴¹³⁵¹³⁶¹³⁷¹³⁸¹³⁹¹⁴⁰¹⁴¹¹⁴²¹⁴³¹⁴⁴

A minority of coverage studies show no effect or mixed results of expansion in certain areas. Many of these findings were included in studies that had additional findings related to coverage or disparity improvements and are also cited above. Some findings within two studies did not support the findings that showed greater coverage benefits of expansion in rural areas. One study found that the

expansion did not result in differential changes for rural vs. urban childless adult populations for overall insurance coverage. An additional study found higher Medicaid growth rates in metropolitan counties compared to rural counties in both expansion and non-expansion states, but the geographic differential in growth rates was much less dramatic in expansion states and analysis at the state level showed much variability across the states. A few studies showed that the broader trend of larger uninsured rate reductions and Medicaid coverage gains in expansion compared to non-expansion states did not occur within some specific racial/ethnic groups, or that there was no effect of Medicaid expansion on coverage disparities by gender or race/ethnicity. Findings within two studies suggested that expansion was associated with an increase in coverage disparities (by gender in one study and by race/ethnicity in another). In addition, one study showed no significant differences in churn rates among low-income adults between 2013 and 2015 based on the state's expansion policy.^{145,146,147,148,149,150,151,152,153,154}

Private Coverage and Waiver Implications

Some studies exploring the effects of Medicaid expansion on private insurance coverage found no evidence of Medicaid expansion coverage substituting for private coverage, while other studies showed declines in private coverage associated with expansion overall or among certain specific population groups. These declines in private coverage may occur if individuals previously covered through employer-sponsored or self-pay insurance opt in to Medicaid given Medicaid's typically lower out-of-pocket costs and more comprehensive benefit packages, or if employers alter their offering of coverage in response to the expansion of Medicaid. Private coverage changes in studies that include states that expanded later than January 2014 may also reflect people above 100% FPL transitioning from subsidized Marketplace coverage to Medicaid after their state adopts the expansion.^{155,156,157,158,159,160,161,162,163,164,165,166,167,168,169}

States implementing the expansion with a waiver have seen similar or larger gains in coverage as states not using waivers, but research finds that some provisions in these waivers present barriers to coverage.

- Studies show that some states initially expanding Medicaid with Section 1115 waivers experienced coverage gains that were similar to gains in states implementing traditional Medicaid expansions. Research comparing Arkansas (which expanded through a premium assistance model) and Kentucky (which expanded through a traditional, non-waiver model) showed no significant differences in uninsured rate declines between 2013 and 2015 in the two states. An analysis of expansion waiver programs in Michigan and Indiana showed that both states experienced uninsured rate reductions between 2013 and 2015 that were higher than the average decrease among expansion states as well as large gains in Medicaid enrollment.^{170,171,172,173}
- A growing body of research suggests that certain Section 1115 waiver provisions that target the expansion population have caused coverage losses or presented barriers to enrollment, particularly in Arkansas related to the implementation of a Medicaid work requirement and in Indiana related to the Healthy Indiana Plan (HIP) 2.0 monthly contribution requirements.^{174,175,176,177,178,179,180,181,182,183}

Impacts on Access and Related Measures

Access to Care and Utilization

Most research demonstrates that Medicaid expansion improves access to care and increases utilization of health care services among the low-income population. Many expansion studies point to improvements across a wide range of measures of access to care as well as utilization of a variety of medications and services. Some of this research also shows that improved access to care and utilization is leading to increases in diagnoses of a range of diseases and conditions and in the number of adults receiving consistent care for a chronic

condition.^{184'185'186'187'188'189'190'191'192'193'194'195'196'197'198'199'200'201'202'203'204'205'206'207'208'209'210'211'212'213'214'215'216'217'218'219'220'221'222'223'224'225'226'227'228'229'230'231'232'233'234'235'236'237'238'239'240'241'242'243'244'245'246'247'248'249'250'251'252'253'254'255'256'257'258'259'260'261'262'263'264'265'266'267'268'269'270} For example:

- **Cancer Diagnosis and Treatment.** Multiple studies found that expansion was associated with significantly greater increases in overall or Medicaid-covered cancer diagnosis rates and/or early-stage diagnosis rates. Multiple studies found an association between expansion and increased access to and utilization of certain types of cancer surgery, with one study finding a decreased disparity in expansion states between Medicaid and privately-insured patients in the odds of undergoing surgery for certain types of cancer.^{271'272'273'274'275'276'277'278'279}
- **Transplants.** Additional studies found a correlation between expansion and increased heart transplant listing rates for African American adults (both overall and among Medicaid enrollees) and increased lung transplant listings for nonelderly adults.^{280'281}
- **Smoking Cessation.** Additional research found decreased cigarette and other nicotine product purchases and increased access, utilization, and Medicaid coverage of evidence-based smoking cessation medications post-expansion in expansion states relative to non-expansion states.^{282'283'284'285}
- **Behavioral Health.** Recent evidence demonstrates that Medicaid expansion states have seen improvements in access to medications and services for the treatment of behavioral health (mental health and substance use disorder (SUD)) conditions following expansion, with many national and multi-state studies showing greater improvements in expansion compared to non-expansion states. This evidence includes studies that have shown that Medicaid expansion is associated with increases in overall prescriptions for, Medicaid-covered prescriptions for, and Medicaid spending on medications to treat opioid use disorder and opioid overdose.^{286'287'288'289'290'291'292'293'294'295'296'297'298'299'300'301'302'303'304'305'306'307'308'309'310}
 - **Medication Assisted Treatment (MAT) for Treatment of Opioid Use Disorder.** Multiple studies have found increases in medication assisted treatment (MAT) drug prescriptions (either overall or Medicaid-covered prescriptions) associated with expansion. Some of these studies also found that in contrast, there was no increase in *opioid* prescribing rates (overall or Medicaid-covered) associated with expansion over the same period. One study found that expansion was associated with an 18% increase in aggregate opioid admissions to specialty treatment facilities, nearly all of which was

driven by a 113% increase in admissions from Medicaid beneficiaries.^{311'312'313'314'315'316'317'318'319}

Multiple recent studies have also found expansion to be associated with improvements in disparities by race/ethnicity, income, education level, insurance type, and employment status in measures of access to and utilization of care.^{320'321'322'323'324'325}

Studies point to changes in patterns of emergency department (ED) utilization. Some studies point to declines in uninsured ED visits or visit rates and increases in Medicaid-covered ED visits or visit rates in expansion states compared to non-expansion states, compared to pre-expansion, or compared to other populations within expansion states. Studies show inconsistent findings about how Medicaid expansion has affected ED volume overall or among specific populations (e.g., Medicaid enrollees or frequent ED users), with some studies showing increases, no change, or declines. Studies also showed decreased reliance on the ED as a usual source of care and a shift in ED use toward visits for higher acuity conditions among individual patients who gained expansion coverage, compared to those who remained uninsured in non-expansion states.^{326'327'328'329'330'331'332'333'334'335}

Evidence suggests that beneficiaries and other stakeholders lack understanding of some waiver provisions designed to change utilization or improve health outcomes. Multiple studies have demonstrated confusion among beneficiaries, providers, and advocates in expansion waiver states around the basic elements of the programs or requirements for participation, as well as beneficiary reports of barriers to completion of program activities (including internet access and transportation barriers). These challenges have resulted in increased costs to beneficiaries, beneficiaries being transitioned to more limited benefit packages, low program participation, or programs not operating as intended in other ways.^{336'337'338'339'340'341'342}

Some study findings did not show that expansion significantly improved some measures of access, utilization, or disparities between population groups. Many of these findings were included in studies that also found related improvements in access, utilization, or disparities measures and are also cited above. Authors of some early studies using 2014 data note that changes in utilization may take more than one year to materialize. Consistent with this premise, a longer-term study found improvements in measures of access to care and financial strain in year two of the expansion that were not observed in the first year.^{343'344'345'346'347'348'349'350'351'352'353'354'355'356'357'358'359'360'361'362'363'364'365'366'367}

Quality of Care, Self-Reported Health, and Health Outcomes

Several studies show an association between Medicaid expansion and improvements in quality of care. These include studies focused on the low-income population broadly, academic medical center or affiliated hospital patients, or community health center patients and look at outcomes including receipt of recommended screenings or recommended care for a particular condition.^{368'369'370'371'372}

Additional studies show effects of expansion on measures of quality hospital care and outcomes. A few studies found that Medicaid expansion was associated with declines in hospital length of stay and increases in hospital discharges to rehabilitation facilities, and one study found an association between expansion and declines in mechanical ventilation rates among patients hospitalized for various conditions. Additional analyses found that, contrary to past studies associating Medicaid insurance with

longer hospital stays and higher in-hospital mortality, the shift in payer mix in expansion states (increase in Medicaid discharges and decrease in uninsured discharges) did not influence length of stay or in-hospital mortality for various types of patients.³⁷³³⁷⁴³⁷⁵³⁷⁶³⁷⁷³⁷⁸³⁷⁹³⁸⁰³⁸¹³⁸²

Multiple studies have found improvements in measures of self-reported health following Medicaid expansions. Additional research has documented provider reports of newly eligible adults showing improved health or receiving life-saving or life-changing treatments that they could not obtain prior to expansion.³⁸³³⁸⁴³⁸⁵³⁸⁶³⁸⁷³⁸⁸³⁸⁹³⁹⁰³⁹¹³⁹²

A growing body of research has found an association between Medicaid expansion and improvements in certain measures of health outcomes. Studies in this area find an association between expansion and improvements in cardiovascular mortality rates, cardiac surgery patient outcomes, 1-year mortality among end-stage renal disease patients initiating dialysis, and perforated appendix admission rates among hospitalized patients with acute appendicitis.³⁹³³⁹⁴³⁹⁵³⁹⁶³⁹⁷

Additional notable findings related to health outcomes include:

- One study suggests that expansion may contribute to infant mortality rate reductions, finding that the mean infant mortality rate rose slightly in non-expansion states between 2014 and 2016, compared to a decline in expansion states over that period (this effect was particularly pronounced among the African-American population). Another study did not find a significant association between expansion and differences in rates of low birth weight or preterm birth outcomes overall, but did find significant improvements in relative disparities for black infants compared with white infants in states that expanded vs. those that did not.³⁹⁸³⁹⁹
- A 2018 study found no evidence of expansion affecting drug-related overdoses or fatal alcohol poisonings. Two studies found expansion was associated with increased odds of tobacco cessation (among adult CHC patients in one study and childless adults in the other).⁴⁰⁰⁴⁰¹⁴⁰²

Some studies did not find significant changes associated with expansion on certain measures of quality of care, self-reported health status, or health outcomes.

- Some studies did not find an association between Medicaid expansion and quality outcomes; many of these studies focused on very narrow population groups and/or found a link between expansion and improvements in quality of care for some of the patient/population groups studied. One study found no significant association between Medicaid expansion and changes in quality of care delivered through Medicaid managed care plans. The authors suggest that this finding shows that the health system has generally been able to absorb new expansion enrollees without sacrificing care for existing enrollees.⁴⁰³⁴⁰⁴⁴⁰⁵⁴⁰⁶⁴⁰⁷⁴⁰⁸⁴⁰⁹⁴¹⁰
- Some studies on specific hospital patient groups found no significant changes associated with expansion in measures of hospital care and outcomes, including rates of emergent admission, admissions from clinic, diagnosis category at admission, admission severity, rapid discharges, lengthy hospitalizations, unplanned readmissions, or failure to rescue. One study found that expansion was associated with an increase in length of stay for adult trauma patients.⁴¹¹⁴¹²⁴¹³⁴¹⁴⁴¹⁵⁴¹⁶⁴¹⁷⁴¹⁸⁴¹⁹⁴²⁰⁴²¹⁴²²⁴²³⁴²⁴

- A small number of studies did not find significant changes in certain measures of self-reported health status or health outcomes, or in disparities between certain population groups in these measures. Given that it may take additional time for measureable changes in health to occur, researchers suggest that further work is needed to provide longer-term insight into expansion's effects on self-reported health and health outcomes.^{425'426'427'428'429'430'431'432'433'434}

Provider Capacity

Many studies conclude that providers have expanded capacity or participation in Medicaid following expansion and are meeting increased demands for care. Studies in this area include findings showing an association of expansion with increases in primary care appointment availability, the likelihood of accepting new patients with Medicaid among non-psychiatry specialist physicians, and Medicaid acceptance and market entry among select medication assisted treatment (MAT) providers. One study found improvements in receipt of checkups, care for chronic conditions, and quality of care even in areas with primary care shortages, suggesting that insurance expansions can have a positive impact even in areas with relative shortages. A survey of Medicaid managed care organizations found that over seven in ten plans operating in expansion states reported expanding their provider networks between January 2014 and December 2016 to serve the newly-eligible population.^{435'436'437'438'439'440'441'442'443'444'445'446'447'448'449'450'451'452'453'454'455'456}

Some studies on measures of provider availability showed no changes associated with expansion. Authors note that findings of no changes may, in some cases, be viewed as favorable outcomes indicating that provider availability is not worsening in expansion states despite the increased demand for care associated with expansion.^{457'458'459'460'461'462'463'464}

Other studies found expansion was linked to problems with provider availability. These include studies showing that Medicaid expansion was associated with longer wait times for appointments or increased difficulty obtaining appointments with specialists.^{465'466'467'468'469'470'471'472'473'474}

Affordability and Financial Security

Research suggests that Medicaid expansion improves the affordability of health care. Several studies show that people in expansion states have experienced reductions in unmet medical need because of cost, with national and multi-state studies showing those reductions were greater than reductions in non-expansion states. Research also suggests that Medicaid expansion results in significant reductions in out-of-pocket medical spending, and multiple studies found larger declines in trouble paying as well as worry about paying future medical bills among people in expansion states relative to non-expansion states. One study found that previously uninsured prescription drug users who gained Medicaid coverage in 2014 saw, on average, a \$205 reduction in annual out-of-pocket spending in 2014. A January 2018 study that focused on the 100-138% FPL population in expansion and non-expansion states also found that Medicaid expansion coverage produced greater reductions than subsidized Marketplace coverage in average total out-of-pocket spending, average out-of-pocket premium spending, and average cost-sharing spending.^{475'476'477'478'479'480'481'482'483'484'485'486'487'488'489'490'491'492'493'494'495'496'497'498'499'500'501}

- Studies have found that Medicaid expansion significantly reduced the percentage of people with medical debt, reduced the average size of medical debt, and reduced the probability of having one or more medical bills go to collections in the past 6 months.^{502'503'504'505'506'507'508'509'510'511'512}
- A study in Ohio showed lower medical debt holding levels among continuously-enrolled expansion enrollees compared to those who unenrolled from expansion and those who had a coverage gap, suggesting that medical debt levels rose even after a relatively short time without Medicaid expansion coverage.^{513'514}

Research also suggests an association between Medicaid expansion and improvements in broader measures of financial stability.^{515'516'517'518'519'520} For example:

- A 2019 national study found an association between Medicaid expansion and a reduction in the rate of poverty by just under 1 percentage point, which the authors estimate corresponds to 690,000 fewer Americans living in poverty.⁵²¹
- Studies have found that Medicaid expansion significantly reduced the average number of collections, improved credit scores, reduced over limit credit card spending, reduced public records (such as evictions, bankruptcies, or wage garnishments), and reduced the probability of a new bankruptcy filing, among other improvements in measures of financial security.^{522'523'524'525'526}
- A Michigan study found an association between expansion and improvements across a broad swath of financial measures.⁵²⁷

Multiple studies have found expansion to be associated with improvements in disparities by income or race/ethnicity in measures of affordability of care or financial security.^{528'529'530'531'532}

Some study findings did not show significant effects of expansion on measures of affordability or financial security. Several of these studies did not identify statistically significant differences in changes in unmet medical need due to cost between expansion and non-expansion states, though authors note that some of these findings may have been affected by study design or data limitations. Other studies did not find changes associated with expansion in trouble or worry about paying medical bills. One study did not find improvements in disparities by race/ethnicity associated with expansion in a measure of unmet care needs due to cost.^{533'534'535'536'537'538'539'540'541'542'543'544}

Economic Effects

State Budgets and Economies

Analyses find effects of expansion on multiple state economic outcomes, including budget savings, revenue gains, and overall economic growth. These positive effects occurred despite Medicaid enrollment growth initially exceeding projections in many states and increases in total Medicaid spending, largely driven by increases in federal spending given the enhanced federal match rate for expansion population costs provided under the ACA (the federal share was 100% for 2014-2016 and phases down after that to 90% by 2020 and for subsequent years). As of Summer 2018, a number of expansion states reported using new or increased provider taxes/fees or savings accrued as a result of the expansion to fund all or part of the state share of expansion costs. While studies showed higher

growth rates in total Medicaid spending (federal, state, and local) following initial expansion implementation in 2014 and 2015 compared to the previous few years, this growth rate slowed significantly in 2016. There is limited research examining the fiscal effects at the federal level from the additional expenditures for the Medicaid expansion or the revenues to support that spending.^{.545'546'547'548'549'550'551'552'553'554'555'556'557'558'559'560'561'562}

- National research found that there were no significant increases in spending from state funds as a result of Medicaid expansion and no significant reductions in state spending on education, transportation, or other state programs as a result of expansion during FYs 2010-2015. During this period, the federal government paid for 100% of the cost expansion. State spending could rise as the federal matching for the expansion phases down to 90%.^{.563}
- Single-state studies in Louisiana and Montana showed that expansion resulted in large infusions of federal funds into the states' economies and significant state savings. For example, a Louisiana annual report showed that expansion saved the state \$199 million in FY 2017 due to multiple factors, including the higher federal match rate for Medicaid populations that were previously funded at the regular state match rate, additional revenue from a premium tax on managed care organizations, and a decrease in state disproportionate share payments to hospitals as the uninsured population decreased. Another Louisiana study found that as a result of the federal infusion of Medicaid expansion dollars into the state's economy, Louisiana derived an additional \$103.2 million in overall state tax receipts (which exceeded the state dollars budgeted for the Medicaid expansion program by close to \$50 million) and local governments derived an additional \$74.6 million in local tax receipts. A study in Montana found positive financial effects for businesses due to infusion of federal dollars to fund health coverage for workers.^{.564'565'566'567}

Multiple studies suggest that Medicaid expansion resulted in state savings by offsetting state costs in other areas, including state costs related to behavioral health services and crime and the criminal justice system. For example, a study on Montana revealed that as Medicaid's role in financing substance use disorder (SUD) services has grown under the state's decision to expand Medicaid, federal Medicaid dollars have replaced federal block grant and state dollars previously used to fund services for uninsured Montanans with SUD. Similarly, a study on California found that the Medicaid expansion almost completely replaced funds flowing through county run safety-net programs in California, representing a transfer of financing responsibility from local taxpayers (mostly counties, which previously bore these costs) to federal taxpayers. Limited research also indicates possible federal and state savings due to decreased SSI participation associated with expansion.^{.568'569'570'571'572'573'574'575'576'577'578}

Medicaid Spending Per Enrollee

Studies have found lower Medicaid spending per enrollee for the new ACA adult eligibility group compared to traditional Medicaid enrollees (including seniors and people with disabilities in some studies and excluding those populations in others) and that per enrollee costs for newly eligible adults have declined over time since initial implementation of the expansion.^{.579'580'581'582'583}

- One analysis found that in 2014, among those states reporting both spending and enrollment data, spending per enrollee for the new adult group was much lower than spending per enrollee

for traditional Medicaid enrollees. Similarly, an analysis of 2012-2014 data from expansion states found that average monthly expenditures for newly eligible Medicaid enrollees were \$180, 21% less than the \$228 average for previously eligible enrollees.^{584,585}

- A June 2017 study showed that per enrollee Medicaid spending declined in expansion states (-5.1%) but increased in non-expansion states (5.1%) between 2013 and 2014. Researchers attributed these trends to the ACA Medicaid expansion, which increased the share of relatively less expensive enrollees in the Medicaid beneficiary population mix in expansion states.⁵⁸⁶

Marketplace Effects

Studies suggest that Medicaid expansion supports the ACA Marketplaces and may help to lower Marketplace premiums. Two national studies showed that Marketplace premiums were significantly lower in expansion compared to non-expansion states, with estimates ranging from 7% lower in 2015 to 11-12% lower in a later study that looked at 2015-2018 data. Another study found that the state average plan liability risk score was higher in non-expansion than expansion states in 2015 (higher risk scores are associated with sicker state risk pools and likely translate to higher premiums). A study in Arkansas showed that the “private option” expansion has helped to boost the number of carriers offering Marketplace plans statewide, generated a younger and relatively healthy risk pool in the Marketplace, and contributed to a 2% drop in the average rate of Marketplace premiums between 2014 and 2015. A study of New Hampshire’s Premium Assistance Program (PAP) population (Medicaid expansion population enrolled in the Marketplace), however, showed higher medical costs for the PAP population compared to other Marketplace enrollees.^{587,588,589,590,591}

Impacts on Hospitals and Other Providers

Research shows that Medicaid expansions result in reductions in uninsured hospital, clinic, or other provider visits and uncompensated care costs, whereas providers in non-expansion states have experienced little or no decline in uninsured visits and uncompensated care. One study suggested that Medicaid expansion cut every dollar that a hospital in an expansion state spent on uncompensated care by 41 cents between 2013 and 2015, corresponding to a reduction in uncompensated care costs across all expansion states of \$6.2 billion over that period.^{592,593,594,595,596,597,598,599,600,601,602,603,604,605,606,607,608,609,610,611,612,613,614,615,616,617,618,619,620,621,622,623,624,625,626,}

^{627,628,629,630,631,632,633,634,635,636,637,638,639,640,641}

- Some studies point to changes in payer mix within emergency departments (EDs), specifically. Multiple studies found significant declines in uninsured ED visits and increases in Medicaid-covered ED visits following expansion implementation (the multi-state or national studies found much smaller changes on these measures in the non-expansion states). In addition, one study found that expansion was associated with a 6.3% increase in ED physician reimbursement per visit in states that expanded coverage for adults from 0% to 138% FPL compared to non-expansion states (however, there were no significant differences from non-expansion states in changes in this measure over time when looking at expansion states that had some pre-ACA coverage for adults).^{642,643,644,645,646,647,648,649}

- Multiple studies found an association between expansion and significant increases in Medicaid coverage of patients/treatment at specialty substance use disorder (SUD) treatment facilities or treatment programs, with two studies also showing associated decreases in the probability that patients at these facilities were uninsured. An additional study found large shifts in sources of payment for SUD treatment among justice-involved individuals following Medicaid expansion in 2014, with significant increases in those reporting Medicaid as the source of payment.^{650'651'652'653'654}
- Numerous recent studies found an association between expansion and payer mix (decreases in uninsured patients and increases in Medicaid patients) among patients hospitalized for certain specific conditions, including a range of cardiovascular conditions and operations; diabetes-related conditions; traumatic injury (among adults in one study and young adults in another); cancer surgery; and operative intervention for benign gallbladder disease. Another analysis found expansion was associated with increases in Medicaid patient admissions for five of the eight types of cancer included in the study, but the study did not look at changes in uninsured cancer patient admissions. Additional studies found that expansion was associated with increases in the proportion of lung transplant listings, pre-emptive listings for kidney transplantation (especially among racial and ethnic minorities), and liver transplant listings with Medicaid coverage, as well as increases in the chances of enrolling in Medicaid during post-liver transplant care (among those who received a pre-ACA liver transplant funded by private insurance).^{655'656'657'658'659'660'661'662'663'664'665'666'667'668'669'670'671}
- Two studies found larger decreases in uncompensated care and increases in Medicaid revenue among hospitals that treat a disproportionate share of low-income patients (DSH hospitals) compared to those that do not. A third study found no significant association of Medicaid expansion with changes in charge-to-cost ratio for certain surgical procedures in safety net hospitals vs. non-safety net hospitals, suggesting that safety net hospitals did not increase charges to private payers in response to expansion-related payer mix changes.^{672'673'674}

Additional studies demonstrate that Medicaid expansion has significantly improved hospital operating margins and financial performance. A study published in January 2018 found that Medicaid expansion was associated with improved hospital financial performance and significant reductions in the probability of hospital closure, especially in rural areas and areas with higher pre-ACA uninsured rates. Another analysis found that expansion's effects on margins were strongest for small hospitals, for-profit and non-federal-government-operated hospitals, and hospitals located in non-metropolitan areas. A third study found larger expansion-related improvements in operating margins for public (compared to nonprofit or for-profit) hospitals and rural (compared to nonrural) hospitals.^{675'676'677'678'679'680}

- A study of Ascension Health hospitals nationwide found that the decrease in uncompensated care costs for hospitals in expansion states was greater than the increase in Medicaid shortfalls between 2013 and 2014, whereas for hospitals in non-expansion states, the increase in Medicaid shortfalls exceeded the decrease in uncompensated care.⁶⁸¹

- A survey of Medicaid managed care organizations found that nearly two-thirds of plans in expansion states reported that the expansion has had a positive effect on their financial performance.⁶⁸²

Some research suggests that savings to providers following expansion may be partially offset by increases in Medicaid shortfalls (the difference between what Medicaid pays and the cost of care for Medicaid patients). One recent study found that while expansion led to substantial reductions in hospitals' uncompensated care costs, savings were offset somewhat by increased Medicaid payment shortfalls (increases were greater in expansion relative to non-expansion states).⁶⁸³

Employment and Labor Market Effects

State-specific studies have documented significant job growth resulting from expansion. A study in Louisiana found that the injection of federal expansion funds created and supported 19,195 jobs (while creating and supporting personal earnings of \$1.12 billion) in sectors throughout the economy and across the state as of SFY 2017. A study in Colorado found that the state supported 31,074 additional jobs due to Medicaid expansion as of FY 2015-2016.⁶⁸⁴⁶⁸⁵⁶⁸⁶

Some studies found expansion was linked to increased employment. National research found increases in the share of individuals with disabilities reporting employment and decreases in the share reporting not working due to a disability in Medicaid expansion states following expansion implementation, with no corresponding trends observed in non-expansion states; other research found a decline in participation in Supplemental Security Income, which requires people to demonstrate having a work-limiting disability and limits their allowable earned income. Another national study found evidence that for many of the demographic groups included in the analysis, expansion was associated with an increase in labor force participation and employment. The study also found a significant decrease in involuntary part-time work for both the full population sample and the sample of those with incomes at or below 138% FPL. A multi-state study found that by the fourth year of expansion, growth in total employment was 1.3 percentage points higher and employment growth in the health care sector was 3.2 percentage points higher in the expansion states studied than in non-expansion states.⁶⁸⁷⁶⁸⁸⁶⁸⁹⁶⁹⁰

Multiple studies showed that expansion supported enrollees' ability to work, seek work, or volunteer. Single-state studies in Ohio and Michigan showed that large percentages of expansion beneficiaries reported that Medicaid enrollment made it easier to seek employment (among those who were unemployed but looking for work) or continue working (among those who were employed). The Michigan study found that 69% of enrollees who were working said they performed better at work once they got expansion coverage. Another study found that 46% of primary care physicians surveyed in Michigan reported that Michigan's Medicaid expansion had a positive impact on patients' ability to work. In addition, a national study found an association between Medicaid expansion and volunteer work (both formal volunteering for organizations and informally helping a neighbor), with significant increases in volunteer work occurring among low-income individuals in expansion states in the post-expansion period (through 2015) but no corresponding increase in non-expansion states. The researchers connect this finding to previous literature showing an association between improvements in individual health and household financial stabilization and an increased likelihood of volunteering.⁶⁹¹⁶⁹²⁶⁹³⁶⁹⁴

Some studies found no effects of expansion on some measures of employment or employee behavior; no studies have found negative effects of expansion on these measures. Measures in this area that showed no changes related to expansion in some studies include measures of employment rates, transitions from employment to non-employment, the rate of job switches, transitions from full- to part-time employment, labor force participation, usual hours worked per week, self-employment, and Supplemental Security Income applications.^{695'696'697'698'699'700}

Conclusion and Implications

As a whole, the large body of research on the effects of Medicaid expansion under the ACA suggests that expansion has had largely positive impacts on coverage; access and related measures, including utilization, quality of care and health outcomes, and affordability and financial security; and economic outcomes, including impacts on state budgets, uncompensated care costs for hospitals and clinics, and employment and the labor market. A small subset of study findings showed no effects of expansion on certain specific measures within some of these categories. Findings on expansion's effect on provider capacity are mixed, with some studies showing improvements, some showing difficulties, and some showing no effect on measures like appointment availability or wait times. Overall, these findings suggest potential for gains in coverage and access as well as economic benefits to states and providers in the remaining non-expansion states that may be considering adopting the expansion in the future.

A limited and still emerging body of literature has looked at measures of expansion effects that do not fit into the coverage, access, and economic categories above. For example, one 2019 study found that Medicaid expansion was associated with a statistically significant decrease in reported cases of neglect for children younger than six years, but no significant change in rates of physical abuse for children under six. A 2017 study found that expansion was negatively associated with the prevalence of divorce among those ages 50-64 and infers that this likely indicates a reduction in medical divorce. An additional group of studies suggests that Medicaid expansion may have significant effects on measures related to individuals' political activity and views. Specifically, studies show associations between Medicaid expansion and increases in voter registration, ACA favorability, and gubernatorial approval. One study found that the increase in Medicaid enrollment following Medicaid expansion was associated with increases in voter turnout for U.S. House races in 2014 compared to 2012 (i.e., a reduction in the size of the usual midterm drop-off in turnout), but another study showed only weak evidence of a potential turnout effect of expansion in the 2014 election, and a consistent lack of any impact on turnout in 2016.^{701'702'703'704'705'706'707}

Multiple recent policy changes, including the repeal of the ACA's individual mandate penalty, shifting immigration policies including proposed "public charge" policies, and new [waiver provisions recently approved by or pending approval](#) from the Trump administration, may have implications for the effects of expansion demonstrated in studies to date. In addition, the effect of expansion on state budgets could change as states have to shoulder an increased share of the cost. Key questions for future consideration include how new Medicaid expansion-related restrictions and requirements will impact states, beneficiaries, and providers, and whether additional states will adopt the expansion and under what conditions. Future research will examine how these policy shifts affect state experiences with Medicaid expansion, and emerging research is building on the literature reviewed in this brief (such as a recent study examining mortality effects of the ACA Medicaid expansion).⁷⁰⁸ We will continue to monitor and update findings on this body of literature as additional studies and state experiences provide insight into

how various factors shape coverage, access to care, and costs in Medicaid expansion states and as states continue to consider expansion and reshape Medicaid coverage.

Methods

This literature review summarizes findings from 324 studies of the impact of state Medicaid expansions under the ACA published beginning in January 2014 (when the coverage provisions of the ACA went into effect). This version of the brief updates earlier versions and includes studies published through June 2019. It includes studies, analyses, and reports published by government, research, and policy organizations using data from 2014 or later and only includes studies that examine impacts of the Medicaid expansion in expansion states. This review excludes studies on impacts of ACA coverage expansions generally (not specific to Medicaid expansion alone), studies investigating potential effects of expansion in states that have not (or had not, at the time of the study) expanded Medicaid, and reports from advocacy organizations and media sources.

To collect relevant studies, we conducted keyword searches of PubMed and other academic health/social policy search engines as well as websites of government, research, and policy organizations that publish health policy-related research. We also used a snowballing technique of pulling additional studies from reference lists in previously pulled papers. While we tried to be as comprehensive as possible in our inclusion of studies and findings that meet our criteria, it is possible that we missed some relevant studies or findings. For each study, we read the final paper/report and summarized the population studied, data and methods used, and findings. In instances of conflicting findings within a study, or if a reviewer had questions about specific findings, multiple reviewers read and classified the study to characterize its findings. In the issue brief text, findings are broken out and reported separately in three broad categories: Medicaid expansion's impact on coverage; access to care and related measures; and economic outcomes for the expansion states. Studies may be cited in multiple of these categories or in multiple places within a category.

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Endnotes

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