

Will Evaluations of Medicaid 1115 Demonstrations That Restrict Eligibility Tell Policymakers What They Need to Know?

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ABSTRACT

ISSUE: With thousands in Arkansas losing their Medicaid benefits under the state's work-requirement demonstration, the importance of evaluating such experiments could not be clearer. In *Stewart v. Azar*, the court concluded that the purpose of Section 1115 demonstrations such as Arkansas's is to promote Medicaid's objective of insuring the poor; evaluations of these demonstrations, as required by law, inform policymakers whether this objective is being achieved.

GOAL: To examine the quality of evaluation designs for demonstrations that test Medicaid eligibility and coverage restrictions.

METHODS: Comparison of state evaluation designs against issues identified in Medicaid impact research.

KEY FINDINGS AND CONCLUSIONS: Evaluation designs for 1115 demonstrations that restrict Medicaid eligibility and coverage either are lacking or contain flaws that limit their policy utility. No federally approved evaluation designs for Medicaid work and community-engagement demonstrations are yet available, and the Centers for Medicare and Medicaid Services has not issued evaluation guidance to states. Evaluations thus lag well behind demonstration implementation, meaning important impact information is being lost. Eligibility restrictions attached to some approved Medicaid expansion demonstrations remain unevaluated. Moreover, evaluations are not sustained long enough to measure critical effects; systematic evaluation of communitywide impact is lacking; and comparisons to states with no Medicaid restrictions are missing. Without robust evaluation, the core purpose of Section 1115 is lost.

TOPLINES

- ▶ In Arkansas, the nation's first-ever Medicaid work requirement demonstration is proceeding even though no federally approved evaluation is under way to assess the impact on beneficiaries.
- ▶ States seeking to impose Medicaid work requirements under Section 1115 are supposed to formally evaluate the impact on beneficiaries — but many states are not doing so.

INTRODUCTION

As thousands of Arkansas residents continue to lose their Medicaid eligibility for failure to satisfy work, community-engagement, and reporting requirements,¹ it is notable that the Centers for Medicare and Medicaid Services (CMS) has permitted the nation's first-ever Medicaid work demonstration to proceed despite the fact no approved evaluation to test the impact of the requirements is under way. In *Stewart v. Azar*,² a federal court, invalidating the U.S. Secretary for Health and Human Services (HHS) approval of Kentucky's Medicaid work demonstration, concluded that Section 1115 of the Social Security Act authorizes experiments only if they are "likely to assist"³ in promoting Medicaid's objective of insuring eligible people.

Section 1115 is not simply a grant of power to run alternative Medicaid programs; it is an experimental statute that permits demonstrations designed to promote program objectives and ensures that their results are properly evaluated.⁴ For this reason, evaluation always has been a core requirement under the law. Because the authority that 1115 confers is experimental, the HHS secretary is obligated to carry "periodic evaluation[s]" of approved experiments, so policymakers can determine whether they are indeed promoting Medicaid's purpose.⁵

WHAT DO MEDICAID WAIVER EVALUATIONS EVALUATE?

Over the years, the many evaluations funded by foundations and federal agencies like the National Institutes of Health have shown how Medicaid policy changes affect health care coverage, access, utilization, quality, and outcomes. Evaluations carried out as part of HHS's formal 1115 demonstration process, however, are uniquely important. They fulfill the secretary's statutory duties and create an official record of the impact that federally sanctioned demonstrations have on people.

All Medicaid 1115 demonstrations raise critical evaluation questions. But given Medicaid's purpose, no evaluation is more important than one conducted for an experiment that will test restrictions on eligibility and benefits. The question is whether, despite these restrictions, the demonstration in fact promotes Medicaid's objective of

providing needed medical assistance to eligible people. Examples of restrictive policies include:

- work requirements
- premiums
- expanded or new reporting rules
- extended disqualification periods
- new restrictions on when coverage begins or how long it will last
- narrower benefits.

Except for work requirements, the Obama administration approved state experiments that test certain eligibility and coverage restrictions, but it did so in the context of broader Medicaid expansion. Under such circumstances, the crucial questions for evaluation become: 1) whether, on balance, even significant coverage restrictions are outweighed by the broader population coverage gains made; 2) who is affected and how; and 3) what possible mitigating safeguards could be introduced.

By contrast, the Trump administration has either approved, or indicated its willingness to consider, 1115 experiments that solely reduce coverage, in Medicaid expansion and nonexpansion states alike.⁶ Assuming that experiments aimed solely at reducing access to Medicaid fit within the scope of 1115 authority (the *Stewart* court did not squarely answer this question), key evaluation questions become: 1) who is affected; 2) what the nature and extent of the impact are; and 3) what gains, if any, outside of access to Medicaid are realized by people exposed to a heightened risk of denial or loss of public insurance.

Federal regulations amplify the 1115 statute's evaluation requirement.⁷ In addition to requiring periodic reports,⁸ the regulations require states to evaluate their demonstrations.⁹ State evaluation designs also are subject to federal approval and oversight.¹⁰ States must publish their approved evaluation plans within 30 days; unlike states' 1115 demonstration proposals themselves, however, the rules do not provide for public comment on evaluation designs.¹¹

The federal rules are relatively detailed on what evaluation designs entail, specifying that the design must describe the demonstration’s hypotheses, the data that will be used, and data collection methods. Designs also must include a description of “how the effects of the demonstration will be isolated from . . . other changes occurring in the State at the same time through the use of comparison or control groups.”¹²

Rather than requiring states to incorporate their evaluation designs into their experimental proposals, CMS specifies a date by which a state must submit its design following approval. The agency has historically allowed states to submit evaluation plans after the start of implementation — as long as 60 days, in recent years. This time allowance appears to be lengthening: recent CMS approvals have permitted states up to 180 days to submit draft evaluation plans. Indeed, in the case of so-called “community engagement” demonstrations, CMS, as of November 2018, had not yet sent guidance regarding its expectations for evaluation design to states with approved or pending demonstrations.¹³ Since evaluations cannot begin without CMS approval, this means their start times likely will be well after the early stages of experiment implementation, when crucial decisions regarding the operationalization of the design are made and a demonstration’s impact begins to be felt.

Exhibit 1 summarizes the key changes being tested under 1115 Medicaid demonstrations approved between 2012 and 2018.

Research into the effects of changes in Medicaid eligibility and coverage span evaluations conducted under 1115 authority as well as those supported by public agencies or private foundations. Evaluations have examined not only gains and losses of coverage but also their consequences at the individual, provider, and community levels. Indeed, changes in Medicaid policy that alter eligibility for large numbers of people can produce effects that go beyond near-term changes in coverage. Moreover, their impact may take years to measure, as the effects of large-scale shifts in coverage in one direction or another ripple through health care systems and entire communities.

These broader effects — gleaned from research into the effects of Medicaid reforms over many decades — may be especially important to examine in the case of health insurance programs targeted at poor people. That is because the poor tend to be concentrated in poor communities, which, in turn, may be particularly sensitive to broader spillover effects.¹⁴ Changes in policy related to eligibility and benefits also impose new demands that can add to program administration complexity and cost.

Over the years, numerous formal evaluations have yielded important information about impact. But the Government Accountability Office (GAO), in examining Section 1115 evaluations, found that while CMS has improved the evaluation process, the evaluations themselves have been neither complete nor timely. They frequently lack intellectual rigor, and they sometimes fail to test important hypotheses raised in approved designs.¹⁵ GAO also noted

Exhibit 1. Eligibility and Benefit Restrictions Under Approved Medicaid 1115 Demonstrations, as of November 2018

Eligibility restriction	States
Deny coverage for failure to meet work or community-engagement requirements	Arkansas, Indiana, Kentucky, New Hampshire, Wisconsin
Waive retroactive eligibility	Arkansas, Indiana, Iowa, Kentucky, New Hampshire, Utah
Charging higher premiums than allowed under normal law	Arizona, Arkansas, Indiana, Iowa, Kentucky, Michigan, Montana
Disqualification periods for nonpayment of premiums or failure to provide certain information (lock-out)	Arkansas, Indiana, Kentucky, Montana, Wisconsin
Healthy behavior incentives	Arizona, Indiana, Iowa, Kentucky, Michigan, Wisconsin
More-limited benefits*	Indiana, Iowa, Kentucky

* More-limited benefits include restriction or exclusion of nonemergency transportation and limits on or exclusion of vision and dental care.

that evaluation results often are not made public, thereby negating their potential value in creating knowledge.¹⁶

HOW WE CONDUCTED THIS STUDY

This analysis examines evaluation designs linked to 1115 demonstrations that test restrictions on eligibility and coverage. We first identified key topics that might be included in such evaluations by reviewing studies that have examined the impact of Medicaid eligibility reforms, both prior to and following ACA enactment. Many of these studies were identified through the Kaiser Family Foundation's ongoing, periodically updated compilation of the research literature.¹⁷ We supplemented this compilation with a search of peer-reviewed articles examining the impact of Medicaid eligibility reforms (see the [Appendix](#) for a summary of some of the key studies).

Our review yielded the following topical areas:

1. How reforms affect individuals' coverage, health care access and utilization, and health outcomes.
2. How reforms affect health care providers.
3. How reforms affect community health and resources and local and state economies.
4. How reforms affect program administration, including administrative complexity, implementation feasibility, and overall program cost.

We then compared these topical areas against approved state evaluation designs for 1115 Medicaid eligibility demonstrations approved by the Obama and Trump administrations. These demonstrations should be understood as a single body of work that could provide key insights into how the same reform might play out under different local conditions. Viewing the current generation of evaluations in this light assumes special importance, given the Trump administration's stated policy of fast-tracking and replicating the same demonstration elements across multiple states.¹⁸ Under these circumstances, coordinated cross-state evaluations would seem essential to the use of multistate testing strategies.

FINDINGS

Posted State Demonstration Evaluation Designs

Of the eight states currently approved to operate the Medicaid expansion on an 1115 demonstration basis, publicly available approved plans were available in six: Arkansas, Iowa, Indiana, Missouri, Montana, and New Hampshire (Kentucky and Arizona did not have approved plans available). Of four states that, as of November 2018, had received approvals to conduct work experiments — Arkansas, Indiana, Kentucky, and New Hampshire — Arkansas is the only state that has submitted evaluation plans for approval. (Kentucky's original demonstration approval was invalidated in June and reapproved November 20.)

The Urban Institute has identified many questions raised by work demonstrations, particularly in relation to who is affected, who qualifies for exemptions, who loses coverage and for what reasons, how long coverage lapses, and whether alternative forms of coverage can be secured.¹⁹ Without an approved and public evaluation design in place, it is not possible to know whether these topics will be captured. This is critical, since although the HHS secretary's approval for Kentucky has been set aside, Arkansas' demonstration already is under way, and early evidence of large-scale risk of loss is apparent.

How Do 1115 State Medicaid Eligibility Demonstrations Approach Key Evaluation Topics?

Exhibit 2 shows the extent to which current state 1115 Medicaid approved evaluation designs reflect the four major topics listed above. Certain topics, unsurprisingly, are common to all approved evaluation designs, such as changes in coverage and access to care, health care utilization, and changes in health behaviors. However, CMS does not appear to have sought comparable evaluation approaches that enable policymakers to more clearly gauge the cross-state effects of common reforms whose details nonetheless may vary in important ways. Although CMS has also commissioned two cross-state evaluations covering certain approved 1115 ACA Medicaid demonstrations, it has made only selected results available

Exhibit 2. Key Topical Areas Under CMS-Approved State 1115 Medicaid Eligibility Expansion Evaluation Plans, as of November 2018

State	Individuals	Health care providers	Community health and welfare	Administrative complexity and cost
Arkansas ¹	Impact on access to care, quality of care, and health outcomes Impact on continuity of care	Impact on health care cost-effectiveness	Not addressed	Impact of premium support on costs of administration
Indiana ²	Impact on insurance rates among low-income residents, including access to employer coverage and use of premium assistance for employer benefits; estimated impact of expansion versus no expansion ³ Impact of expansion on select population subgroups ³ Impact on access to health services among beneficiaries Impact on value-based decision-making and personal health responsibility through required contributions and incentives Impact on use of preventive primary and chronic disease management services to improve health outcomes Impact on beneficiary understanding and experience with Medicaid ³	Not addressed	Impact of employment referrals under initial voluntary work program on employment, income, and Medicaid eligibility	Impact on program efficiency Feasibility of demonstration implementation, both overall and key components ³
Iowa ⁴	Impact on beneficiary insurance coverage and coverage gaps as a result of eligibility churn Impact on beneficiary access to care Impact on quality of care Impact of premium incentives and copayment disincentives Impact of engaging in behavior incentives on health outcomes ⁵ Impact following disenrollment ⁵	Impact of healthy behavior incentives on providers ⁵ Impact on provider network adequacy Impact on health care costs	Not addressed	Not addressed
Michigan ⁶	Impact on insurance rates generally and Medicaid enrollment Impact on beneficiary healthy behaviors and health outcomes including reduction in emergency department utilization and avoidable hospital admissions Impact on use of preventive care Impact of increased monthly contribution requirements and cost-sharing on enrollment and efficient use of care by beneficiaries	Impact on uncompensated care	Not addressed	Not addressed
Montana ⁷	Impact of Medicaid expansion compared to enrollment without expansion, both generally and for specific population subgroups Beneficiary understanding and experience with the program	Not addressed	Not addressed	Impact on program administration overall and with respect to specific demonstration components
New Hampshire ⁸	Impact on coverage and coverage gaps Impact on coverage and health plan enrollment continuity Impact on emergency care use and avoidable hospital utilization and admission Impact on access to primary, specialty, and preventive services Impact on satisfaction with care Impact on access to nonemergency transportation	Impact on willingness of entities sponsoring qualified health plans and Medicaid managed care plans to participate across both subsidized markets Impact on costs of care	Not addressed	Not addressed

Notes

- Center for Medicaid and CHIP Services, *Arkansas Health Care Independence Program (“Private Option”) Approved Evaluation Plan* (Centers for Medicare and Medicaid Services, Mar. 2014).
- State of Indiana, *Healthy Indiana Plan 2.0, Final Evaluation Plan* (State of Indiana, Dec. 28, 2015).
- Social and Scientific Systems and Urban Institute, *Evaluation Design Report for Indiana HIP 2.0 Federal Evaluation* (SSS and Urban, May 2017).
- Center for Medicaid and CHIP Services, *Iowa Wellness Plan Evaluation Plan Approval* (Centers for Medicare and Medicaid Services, June 2014); and Center for Medicaid and CHIP Services, *Iowa Marketplace Choice Plan Evaluation Plan Approval* (Centers for Medicare and Medicaid Services, June 2014).
- Center for Medicaid and CHIP Services, *Iowa Wellness Plan Healthy Behaviors Evaluation Plan Approval* (Centers for Medicare and Medicaid Services, Apr. 2015).
- Center for Medicaid and CHIP Services, *Healthy Michigan Approved Evaluation Plan* (Centers for Medicare and Medicaid Services, Oct. 2015); and Center for Medicaid and CHIP Services, *Healthy Michigan Approved Evaluation Plan on Cost-Effectiveness* (Centers for Medicare and Medicaid Services, Aug. 2017).
- Social and Scientific Systems and Urban Institute, *Evaluation Design Report for Montana HELP Federal Evaluation* (SSS and Urban, May 2017).
- Center for Medicaid and CHIP Services, *2016 New Hampshire Health Protection Program — Premium Assistance Program Waiver (NHHPP PAP)* (Centers for Medicare and Medicaid Services, Mar. 2016).

and does not indicate whether it is considering these limited emerging findings to be relevant to its ongoing 1115 review and approval process.

We also find that certain topics remain largely unaddressed. One example is the possible spillover effects on health care providers when insurance coverage for an entire population is altered — an especially important consideration in communities where poverty is concentrated and the impact can be broad enough to affect the economic sustainability of the local health care system.²⁰ Similarly, evaluation designs are inconsistent in the extent to which they are expected to address the feasibility and cost to government of changing program rules, such as new enrollment restrictions that add costs to the eligibility determination process. Likewise, benefit restrictions that vary by individual beneficiary characteristics could trigger new costs in determining the scope of benefits or level of cost-sharing owed.

Key waivers of federal law appear to remain unevaluated as well. For example, the lack of evaluation designs for demonstrations that eliminate retroactive eligibility is notable, especially given the long-standing role this process has played in protecting people and health care providers alike from heavy levels of medical debt and uncompensated care.

While a couple of state designs appear to pose “pre and post” questions (Medicaid enrollment under demonstration conditions compared to what it might have been previously), there do not appear to be evaluation features aimed at ensuring pre-and-post-impact analysis in all demonstration states, or between demonstration states and states expanding Medicaid under the ACA and states doing so under Medicaid’s normal operating standards.

Finally, the duration of evaluations appears to be uncertain. For example, with Office of Management and Budget approval, the Trump administration has terminated a previously scheduled participant impact survey for the Healthy Indiana Demonstration that would have examined the longer-term effects of premiums and enrollment lock-out periods.²¹ This raises the potential that major downstream consequences will go unobserved.

Premature cancellation of evaluations not only creates the possibility that important consequences will be missed entirely, but it also can mean that early, preliminary results are treated as final when, in fact, they are not and are subject to change. For example, in the early stages of an experiment that imposes premiums on the poor, a state agency may waive the premiums because the affected enrollees are still learning to navigate the new rules. As the agency moves toward more aggressive enforcement, the impact of premiums may produce effects that differ substantially from those observed during the grace period. Alternatively, the early results could suggest that premiums do not produce a major impact on enrollment or retention.

DISCUSSION

The GAO reports that by the end of 2016, nearly three-quarters of all states operated at least part of their Medicaid program under Section 1115 authority and that during fiscal year 2015, expenditures under 1115 accounted for one-third of total program spending.²² At the same time, as the agency notes, evaluation has played only a limited role in program administration, despite the fact it is a core feature of the 1115 statute.

The Medicaid expansion demonstrations have the potential to affect coverage for millions of people while yielding important information for policymakers regarding the effects of eligibility conditions more restrictive than what is normally permitted. Furthermore, with at least one major Medicaid work experiment under way, evaluation has taken on a special urgency in helping policymakers understand why the demonstration is costing thousands of people their coverage each month. Early anecdotal evidence suggests that this figure likely includes many beneficiaries who are working or actively looking for work but cannot navigate the online reporting system or find enough work to satisfy the minimum weekly requirement of 20 hours.²³

This analysis suggests that current evaluations will yield far less information than they could. Because evaluation designs and approval are delayed until, potentially, well after the demonstration has begun, there is a lost

opportunity to establish a predemonstration baseline against which change and its impact will be measured. Furthermore, at least one key eligibility change — eliminating retroactive eligibility — appears to be going forward without an evaluation plan in states permitted to test the restriction as part of their demonstrations. Major topics, such as the imposition of premiums, may receive inadequate attention. This is particularly true in the case of states that initially take a gentle approach to enforcing a premium policy, becoming stricter about payment and the lock-out consequences for nonpayment only as time passes. Additionally, comparative assessments of common changes across demonstrations appear to be lacking. Although CMS has commissioned a federal evaluation of certain issues across several demonstration states, published findings are limited and the agency has left unaddressed how these findings are informing ongoing eligibility restriction demonstrations.

The Trump administration also appears to be moving to lengthen the time between waiver implementation and the official start of an evaluation, thereby affecting the potential to capture the early effects of change while also depriving the evaluation of a critical preimplementation baseline against which to measure the impact of change. Indeed, CMS has yet to inform states with approved or pending work experiments what the agency expects their evaluations will capture. The administration also appears to be limiting the duration of evaluations, even in the case of changes whose full effects will only be known over a longer period or whose early impact may change appreciably over time.

These gaps and limitations are especially important now when potentially large numbers of Medicaid demonstrations aimed at restricting eligibility may soon be in full swing. These demonstrations carry significant implications for access, coverage, health care utilization, and uncompensated care, and because of the concentration of poverty, their implications may be felt communitywide. And while the cost and operational feasibility associated with implementing complex restrictions on eligibility and benefits are potentially considerable, inclusion of these considerations in evaluation designs is highly uneven. All of this argues for an evaluation process of enhanced rigor.

NOTES

1. Catherine Rampell, “[Are Work Requirements Inherently, Irredeemably Flawed?](#),” *Washington Post*, Nov. 21, 2018).
2. *Stewart v. Azar*, 2018 WL 3203384 (D.D.C. June 29, 2018).
3. 42 U.S.C. § 1315(a).
4. *Gresham v. Stewart*, Civ. Action No. 1:18-cv-01900, [Brief for Deans Chairs and Scholars as Amici Curiae in Support of Plaintiffs](#) (D.D.C., Nov. 7, 2018).
5. 42 U.S.C. § 1315(d)(2)(E).
6. Sara Rosenbaum et al., “[State 1115 Proposals to Reduce Medicaid Eligibility: Assessing Their Scope and Projected Impact](#),” *To the Point* (blog), Commonwealth Fund, Jan. 11, 2018.
7. Sara Rosenbaum and Genevieve Kenney, [State Flexibility in a New Era: What Are the Research Priorities for Section 1115 Demonstrations?](#) (AcademyHealth, Feb. 2018).
8. 42 U.S.C. § 1315(d).
9. 42 U.S.C. § 1315 (d)(2)(E).
10. 42 C.F.R. § 431.424.
11. 42 C.F. R. § 431.424(c).
12. 42 C.F.R. § 431.424(c).
13. Letter from Andrea J. Casart to Dawn Stehle regarding Arkansas’ draft evaluation design (Nov. 1, 2018).
14. Elizabeth Kneebone and Natalie Holmes, [U.S. Concentrated Poverty in the Wake of the Great Recession](#) (Brookings Institution, Mar. 2016).
15. Government Accountability Office, [Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures](#) (GAO, Jan. 19, 2018).
16. GAO, *Medicaid Demonstrations*, 2018.
17. Larisa Antonisse et al., [The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review](#) (Henry J. Kaiser Family Foundation, Mar. 2018).

18. Center for Medicaid and CHIP Services, *CMCS Informational Bulletin: Section 1115 Demonstration Process Improvements* (Centers for Medicare and Medicaid Services, Nov. 6, 2017).
19. Heather Hahn et al., *Guidance on Medicaid Work and Community Engagement Requirements Raises Many Important Questions* (Urban Institute, Jan. 2018).
20. Institute of Medicine, *A Shared Destiny: Community Effects of Uninsurance* (National Academies Press, 2003).
21. Virgil Dickson, “CMS Scales Back Evaluation Plans for Indiana Medicaid Waiver,” *Modern Healthcare*, Apr. 9, 2018).
22. GAO, *Medicaid Demonstrations*, 2018.
23. Medicaid and CHIP Payment and Access Commission, *Letter to Secretary Alex Azar, recommending a pause on work experiments* (MACPAC, Nov. 8, 2018).

APPENDIX. SUMMARY OF KEY STUDIES OF MEDICAID ELIGIBILITY REFORMS ADOPTED PRIOR TO ACA PASSAGE

Study	Summary and principal findings	Citations in other literature (per Google Scholar)
Lurie et al. (1984) ¹	<p>This study evaluated the effects on access to care, satisfaction with care, and health outcomes for medically indigent adults six months after termination of Medi-Cal (California Medicaid) benefits. Loss of coverage led to the following outcomes:</p> <ul style="list-style-type: none"> • Decrease in the number of medically indigent adults who could name a regular source of care or thought they could obtain medical care when they needed it. • Lower levels of satisfaction with medical care. • Deterioration of general health and blood pressure control among hypertensive subjects. 	Cited 411 times
Lurie et al. (1986) ²	<p>This study evaluated the effects on access to care, satisfaction with care, and health outcomes for medically indigent adults one year after termination of Medi-Cal (California Medicaid) benefits. Loss of coverage led to the following outcomes:</p> <ul style="list-style-type: none"> • 12 months after termination of Medi-Cal benefits: <ul style="list-style-type: none"> – Sixty-eight percent of subjects reported a specific episode in which they had not obtained care that they believed they needed; of those, 78% listed cost as a reason for not obtaining care. – Use of outpatient services decreased by 45%. – There was further deterioration of general health. – Blood-pressure control was significantly worse. 	Cited 259 times
Finkelstein et al. (2012) ³	<p>This study examined the effects of expanding access to public health insurance (2008 Oregon Medicaid Lottery) on the health care use, financial strain, and health of low-income adults one year after the lottery. Expansion of coverage to the uninsured led to the following outcomes:</p> <ul style="list-style-type: none"> • Compared to those who were not selected by the lottery, those who were selected experienced: <ul style="list-style-type: none"> – Higher health care utilization (including primary and preventive care as well as hospitalization). – Lower out-of-pocket medical expenditures and medical debt (including fewer bills sent to collection). – Better self-reported physical and mental health. 	Cited 834 times
Baicker et al. (2013) ⁴	<p>This study examined the effects of expanding access to public health insurance (2008 Oregon Medicaid Lottery) on the health care use, financial strain, and health of low-income adults two years after the lottery. Expansion of coverage to the uninsured led to the following outcomes:</p> <ul style="list-style-type: none"> • Increase in the use of health care services. • Increase in the rate of diabetes detection and management. • Lower rates of depression. • Reduction in financial strain. 	Cited 605 times
Taubman et al. (2014) ⁵	<p>This study examined the effects of expanding access to public health insurance (2008 Oregon Medicaid Lottery) on emergency department (ED) use. The study found:</p> <ul style="list-style-type: none"> • Medicaid increased ED visits by 40% in the first 15 months. 	Cited 301 times
Baicker et al. (2017) ⁶	<p>This study examined the effects of expanding access to public health insurance (2008 Oregon Medicaid Lottery) on medication use. The study found increased Medicaid coverage was associated with:</p> <ul style="list-style-type: none"> • An increased proportion of individuals with at least one prescription medication. • An increased number of prescription medications per person. 	Cited 2 times
Sommers et al. (2014) ⁷	<p>This study evaluated Massachusetts' 2006 health reform to determine whether the reform was associated with changes in all-cause mortality and mortality from causes amenable to health care. Health reform was associated with:</p> <ul style="list-style-type: none"> • Significant declines in all-cause mortality and deaths from causes amenable to health care. 	Cited 140 times

Study	Summary and principal findings	Citations in other literature (per Google Scholar)
Sommers et al. (2012) ⁸	This study evaluated the Medicaid eligibility expansions in New York, Maine, and Arizona and examined whether Medicaid expansions were associated with changes in mortality and other health-related measures. State Medicaid expansions were significantly associated with: <ul style="list-style-type: none"> • Reduced mortality. • Improved coverage. • Improved access to care. • Improved self-reported health. 	Cited 374 times
Aliu et al. (2014) ⁹	Using the natural experiment of Medicaid expansion in New York State in October 2001, this study examined whether Medicaid expansion increased access to common musculoskeletal procedures for Medicaid beneficiaries. Medicaid expansion led to the following outcome: <ul style="list-style-type: none"> • Increased access to common musculoskeletal procedures for Medicaid beneficiaries. 	Cited 16 times
McMorrow et al. (2016) ¹⁰	This study assessed the effects of past Medicaid eligibility expansions to parents on coverage, access to care, out-of-pocket spending, and mental health outcomes. Expanding Medicaid eligibility: <ul style="list-style-type: none"> • Increased insurance coverage. • Reduced unmet needs because of cost and out-of-pocket spending. • Improved mental health status among low-income parents. 	Cited 24 times
Wright et al. (2005) ¹¹	This study examined the impacts of increases in cost-sharing for Oregon’s Medicaid Program (Oregon Health Plan [OHP]). Increases in cost-sharing led to the following outcomes: <ul style="list-style-type: none"> • A large reduction in OHP membership. • Compared to those who left OHP for other reasons, those who left OHP because of cost-sharing increase reported: <ul style="list-style-type: none"> – Inferior access to needed care. – Utilizing primary care less often. – Utilizing hospital emergency rooms more often. 	Cited 78 times
Currie & Gruber (1996) ¹²	This study evaluated the effect of public insurance for children on their utilization and health outcomes by examining expansions (from 1984 to 1992) of the Medicaid program to low-income children. Expansion of Medicaid eligibility led to the following outcomes: <ul style="list-style-type: none"> • Increase in the utilization of medical care (particularly care delivered in physician’s offices). • Sizable and significant reduction in child mortality. 	Cited 797 times
Baldwin et al. (1998) ¹³	This study evaluated the effect of Washington State’s expansion of prenatal services for Medicaid-enrolled women. Expansion of these services led to: <ul style="list-style-type: none"> • Decrease in the low-birthweight rate of medically high-risk women. 	Cited 121 times
DeLeire et al. (2013) ¹⁴	This study evaluated the effect of a 2009 Wisconsin program that expanded public health insurance for low-income uninsured childless adults. Expansion of public health insurance led to the following outcomes: <ul style="list-style-type: none"> • Outpatient visits increased 29 percent. • Inpatient hospitalizations declined 59 percent. • Preventable hospitalizations decreased 48 percent. 	Cited 57 times
Currie & Gruber (1996) ¹⁵	This study evaluated the effects of changes in Medicaid eligibility for pregnant women between 1979 and 1992. A simulation model for each state’s policy change found that: <ul style="list-style-type: none"> • Eligibility of pregnant women increased 30 percentage points but not differentially by state. • Infant mortality decreased 8.5 percent. • Earlier changes to Medicaid eligibility restricted to low-income groups had larger effects on birth outcomes. 	Cited 662 times

Study	Summary and principal findings	Citations in other literature (per Google Scholar)
Cutler & Gruber (1996) ¹⁶	<p>This study evaluated the effects of Medicaid expansions for pregnant women and children between 1987 and 1992. The study found that:</p> <ul style="list-style-type: none"> • Approximately half of the increase in Medicaid coverage was associated with a decrease in private insurance coverage. 	Cited 863 times
Yelowitz (1995) ¹⁷	<p>This study evaluated the effects of Medicaid eligibility expansions that were targeted toward young children. The study found that:</p> <ul style="list-style-type: none"> • Increases to income limits resulted in decreased participation in the Aid to Families with Dependent Children program and increased labor force participation among women. 	Cited 338 times
Dubay & Kenney (1997) ¹⁸	<p>This study evaluated the effects of Medicaid expansions aimed at pregnant women. The study found that:</p> <ul style="list-style-type: none"> • Two-thirds of all pregnant women who were eligible for Medicaid coverage enrolled. • The share of poor pregnant women who were uninsured fell by roughly 7 percentage points. • For pregnant women with incomes below 100% of the federal poverty level, the share with Medicaid coverage increased by 4.4 percentage points between 1988 and 1992. 	Cited 158 times

Appendix Notes

1. Nicole Lurie et al., "[Termination from Medi-Cal — Does It Affect Health?](#)," *New England Journal of Medicine* 311, no. 7 (Aug. 16, 1984): 480–84.
2. Nicole Lurie et al., "[Termination of Medi-Cal Benefits: A Follow-Up Study One Year Later](#)," *New England Journal of Medicine* 314, no. 19 (May 8, 1986): 1266–68.
3. Amy Finkelstein et al., "[The Oregon Health Insurance Experiment: Evidence from the First Year](#)," *Quarterly Journal of Economics* 127, no. 3 (Aug. 2012): 1057–106.
4. Katherine Baicker et al., "[The Oregon Experiment — Effects of Medicaid on Clinical Outcomes](#)," *New England Journal of Medicine* 368, no. 18 (May 2, 2013): 1713–22.
5. Sarah L. Taubman et al., "[Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment](#)," *Science* 343, no. 6168 (Jan. 17, 2014): 263–68.
6. Katherine Baicker et al., "[The Effect of Medicaid on Medication Use Among Poor Adults: Evidence from Oregon](#)," *Health Affairs* 36, no. 12 (Dec. 2017): 2110–14.
7. Massachusetts' 2006 health reform (see note 1: Lurie et al., 2014) included various components, including Medicaid expansion, subsidized private insurance, and an individual mandate. This study evaluated the impact of the 2006 health reform in its entirety. Benjamin D. Sommers, Sharon K. Long, and Katherine Baicker, "[Changes in Mortality After Massachusetts Health Care Reform: A Quasi-Experimental Study](#)," *Annals of Internal Medicine* 160, no. 9 (May 6, 2014): 585–93.
8. Benjamin D. Sommers, Katherine Baicker, and Arnold M. Epstein, "[Mortality and Access to Care Among Adults After State Medicaid Expansions](#)," *New England Journal of Medicine* 367, no. 11 (Sept. 13, 2012): 1025–34.
9. Oluseyi Aliu et al., "[The Effect of Pre-Affordable Care Act \(ACA\) Medicaid Eligibility Expansion in New York State on Access to Specialty Surgical Care](#)," *Medical Care* 52, no. 9 (Sept. 2014): 790–95.
10. Stacey McMorrow et al., "[Medicaid Expansions from 1997 to 2009 Increased Coverage and Improved Access and Mental Health Outcomes for Low-Income Parents](#)," *Health Services Research* 51, no. 4 (Aug. 2016): 1347–67.
11. Bill J. Wright et al., "[The Impact of Increased Cost Sharing on Medicaid Enrollees](#)," *Health Affairs* 24, no. 4 (July/Aug. 2005): 1106–16.
12. Janet Currie and Jonathan Gruber, "[Health Insurance Eligibility, Utilization of Medical Care, and Child Health](#)," *Quarterly Journal of Economics* 111, no. 2 (May 1996): 431–66.
13. Laura-Mae Baldwin et al., "[The Effect of Expanding Medicaid Prenatal Services on Birth Outcomes](#)," *American Journal of Public Health* 88, no. 11 (Nov. 1998): 1623–29.
14. Thomas DeLeire et al., "[Wisconsin Experience Indicates That Expanding Public Insurance to Low-Income Childless Adults Has Health Care Impacts](#)," *Health Affairs* 32, no. 6 (June 2013): 1037–45.
15. Janet Currie and Jonathan Gruber, "[Saving Babies: The Efficacy and Cost of Recent Changes in the Medicaid Eligibility of Pregnant Women](#)," *Journal of Political Economy* 104, no. 6 (Dec. 1996): 1263–96.
16. David M. Cutler and Jonathan Gruber, "[Does Public Insurance Crowd Out Private Insurance?](#)" *Quarterly Journal of Economics* 111, no. 2 (May 1996): 391–430.
17. Aaron S. Yelowitz, "[The Medicaid Notch, Labor Supply, and Welfare Participation: Evidence from Eligibility Expansions](#)," *Quarterly Journal of Economics* 110, no. 4 (Nov. 1995): 909–39.
18. Lisa Dubay and Genevieve Kenney, "[Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?](#)" *Health Affairs* 16, no. 1 (Jan./Feb. 1997): 185–93.

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