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

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A substantial body of research has investigated effects of the Medicaid expansion under the Affordable Care Act (ACA) on coverage; access to care, utilization, affordability, and health outcomes; and various economic measures. This issue brief summarizes findings from 202 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 February 2018.[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 and other needs, and providers' financial stability.

Key Findings

This body of research suggests that the expansion presents an opportunity for gains in coverage, improvements in access and financial security, 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 through a waiver have seen coverage gains, but some waiver provisions appear to compromise coverage. Data do not support a relationship between states' expansion status and community-based services waiver waiting lists.
- **Access to care, utilization, affordability, and health outcomes:** Most research demonstrates that Medicaid expansion has positively affected access to care, utilization of services, the affordability of care, and financial security among the low-income population. However, findings on provider capacity were mixed, with some studies suggesting that provider shortages are a challenge in certain contexts. Studies show improved self-reported health following expansion, and multiple new studies demonstrate a positive association between expansion and health outcomes. Further research is needed to more fully determine effects on outcomes given that it may take additional time for measureable changes in health outcomes to occur.
- **Economic measures:** Analyses find positive effects of expansion on numerous economic outcomes, despite Medicaid enrollment growth initially exceeding projections in many states. Total (federal and state) Medicaid spending increased following expansion implementation, but research suggests that there were no significant increases in state spending from state funds as a result of the expansion through 2015 (although an uptick in state Medicaid spending growth was projected for 2017 and later years as the federal share for the expansion population phases down from 100% to 90%). Studies also show that Medicaid expansions result in reductions in uncompensated care costs for hospitals and clinics as well as positive or neutral effects on employment and the labor market.

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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, utilization, affordability, and health outcomes; 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 2017 and early 2018 have continued to 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, and providers' financial stability. Among other findings, new studies in these areas show that expansion is associated with infant mortality rate reductions, increases in cancer diagnosis rates (especially early-stage diagnosis rates), increases in prescriptions for and Medicaid coverage of medications to treat opioid use disorder and opioid overdose, and reduced probability of hospital closure (particularly in rural areas).

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. While future research will be necessary to study the effects of new waiver provisions recently approved by or pending approval from the Trump administration, findings from this literature review on states with existing expansion waivers (such as Indiana) suggest that adding new restrictions or program complexities to Medicaid through Section 1115 waivers could compromise coverage and access gains achieved under expansion or slow future progress.

Impacts on Coverage

Uninsured Rate and Medicaid Coverage Changes

Studies show that Medicaid expansion results in significant coverage gains and reductions in uninsured rates.

- States expanding their Medicaid programs under the ACA have seen large increases in Medicaid enrollment, driven by enrollment of adults made newly eligible for Medicaid as well as enrollment growth among individuals who were previously eligible for but not enrolled in Medicaid (known as the "woodwork" or "welcome mat" effect that occurred largely due to incentives to increase enrollment in coverage provided under the broader ACA). In comparison, non-expansion states have experienced slower enrollment growth.[2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24]
- Numerous analyses demonstrate that Medicaid expansion states experienced large reductions in uninsured rates and that these reductions significantly exceed those in non-expansion states.[25,26,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,43,44,45,46,47,48,49,50,51,52,53,54,55,56]

    - Recent studies have shown that expansion-related enrollment growth in Medicaid and declines in uninsured rates in expansion states continued in 2015 and 2016, and that the gap between coverage rates in expansion and non-expansion states continued to widen after 2014. One study found that the greater uninsured rate decline in expansion compared to non-expansion states was isolated among the population that is ineligible for ACA coverage in non-expansion states (those below 100% FPL).[57,58,59,60,61 ,62]

- The sharp declines in uninsured rates among the low-income population in expansion states are widely attributed to gains in Medicaid coverage.[63,64,65,66,67,68]
- Research does not support a relationship between states' Medicaid expansion status and home and community-based services (HCBS) waiver waiting lists. One study found that most expansion states either had no HCBS waiver waiting list or had a decrease in their waiting list from 2014 to 2015, and more non-expansion states than expansion states experienced an HCBS waiver waiting list increase between 2014 and 2015.[69]
- Studies exploring the potential for Medicaid expansion to "crowd-out" private insurance have found mixed results, with most showing no evidence of "crowd-out" and some showing slight declines in private coverage in expansion states following expansion.[70,71,72,73,74,75,76,77,78]

Similar coverage gain patterns have occurred within specific vulnerable populations.

- While many studies focused on the low-income population broadly, several studies identified larger coverage gains in expansion versus non-expansion states for specific vulnerable populations, including young adults, prescription drug users, people with HIV, veterans, parents, mothers, women of reproductive age (with and without children), children, lesbian, gay, and bisexual adults, newly diagnosed cancer patients, women diagnosed with a gynecologic malignancy, low-income workers, low-educated adults, early retirees, and childless adults with incomes under 100% FPL.[79,80,81,82,83,84,85,86,87,88,89,90,91,92,93,94,95,96,97,98,99,100,101,102]
- Multiple recent analyses demonstrate that Medicaid expansion is having a disproportionately positive impact in rural areas in expansion states, where growth in Medicaid coverage and declines in uninsured rates have exceeded those in metropolitan areas in expansion states and both rural and metropolitan areas in non-expansion states. One 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.[103,104,105,106]
- Multiple studies showed that this trend of larger uninsured rate reductions and Medicaid coverage gains in expansion states compared to non-expansion states occurred across the major racial/ethnic categories. Additional research also suggests that Medicaid expansion has helped to reduce disparities in coverage by income and age, and research shows improvements in disparities by race/ethnicity, with mixed outcomes for some specific racial and ethnic groups.[107,108,109,110,111,112,113,114,115,116]

- One 2017 study demonstrated a clear “welcome-mat” effect of Medicaid expansion on enrollment in public coverage among children who were already eligible for Medicaid. Enrollment increases in 2014 and 2015 among children whose parents became newly eligible for Medicaid under the expansion outpaced coverage increases among children in families without newly eligible parents by more than double.[117]

Coverage Effects Under Section 1115 Medicaid Expansion Waivers

States implementing the expansion through a waiver have seen similar gains in coverage, but some provisions in these waivers may present barriers to coverage.

- Studies show that states expanding Medicaid through Section 1115 waivers have experienced coverage gains that are 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.[118,119,120,121]
- Data from Indiana, which implemented the expansion through a Section 1115 waiver, show that its required monthly contributions may have created an enrollment barrier for some adults. In the Healthy Indiana Plan (HIP) 2.0 Medicaid expansion program, individuals above 100% FPL are either not enrolled or disenrolled from HIP 2.0 coverage for unpaid monthly contributions. A report assessing the program showed that between February 1, 2015 and November 30, 2016, 57,189 members were disenrolled or not enrolled due do non-payment (representing 29% of those that could be affected by the policy).[122,123]
- Evidence also suggests that beneficiaries and other stakeholders often do not fully understand complex enrollment policies such as the HIP 2.0 monthly contribution policy, and these policies can deter eligible people from enrolling in coverage. The March 2017 HIP 2.0 evaluation found that 14% of all HIP enrollees above 100% FPL, 33% of individuals who were disenrolled for not making a monthly contribution, and 40% of individuals who were not enrolled because they did not make a first monthly contribution reported being unaware that they could be disenrolled for non-payment.[124,125,126]

Impacts on Access to Care, Utilization, Affordability, and Health Outcomes

Access to Care and Utilization

Most research demonstrates that Medicaid expansion positively impacts access to care and utilization of health care services among the low-income population, but some studies have not identified significant effects in these areas.

- Many expansion studies point to improvements across a wide range of measures of access to care as well as utilization of some 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.[127,128,129,130,131,132,133,134,135,136,137,138,139,140,141,142,143,144,145,146,147,148,149,150,151,152,153,154,155,156,157,158,159,160,161,162,163,164,165,166,167,168,169,170,171,172,173,174,175,176,177] For example:

- Two studies found that expansion was associated with significantly greater increases in cancer diagnosis rates (especially early-stage diagnosis rates), and another study showed an association of expansion with an increase in the probability of early uncomplicated presentation for patients admitted to hospitals for one of five common surgical conditions. A fourth study found that Medicaid expansion was correlated with increased heart transplant listing rates for African American patients (both overall and among Medicaid enrollees, specifically).[178,179,180,181]
- Recent evidence demonstrates that compared to non-expansion states, Medicaid expansion states have seen greater improvements in access to medications and services for the treatment of behavioral and mental health conditions. 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. Additional research found increased utilization and Medicaid coverage of evidence-based smoking cessation medications post-expansion in expansion states relative to non-expansion states.[182,183,184,185,186,187,188,189,190,191,192,193]
- Multiple recent studies have also found expansion to be associated with improvements in disparities by race and income, education level, and employment status in measures of access to and affordability of care.[194,195,196,197]
- Studies conducted in 2017 and 2018 began to explore the effect of the Medicaid expansion on quality of care. A January 2018 study found that for patients with one of five common surgical conditions admitted to an academic medical center or affiliated hospital, expansion was associated with a significantly greater probability of receiving optimal care. Another study found that at federally funded community health centers, expansion was associated with improved quality on four of eight measures examined: asthma treatment, Pap testing, body mass index assessment, and hypertension control. A third study found some improvement in perceived quality of care associated with expansion in 2015, but this result did not persist in 2016.[198,199,200]
- Some studies point to changes in patterns of use of emergency departments (EDs). Two recent single-state studies in Maryland and Illinois found declines in uninsured ED visits and increases in Medicaid-covered ED visits following expansion implementation. Some studies have explored expansion's impact on total emergency department (ED) volume and utilization patterns. A single-state study in Maryland found no significant relationship between Medicaid expansion and changes in total ED volume by hospital. An Illinois study found an increase in total ED visits after ACA implementation, but this included an increase in visits by individuals with private coverage. One study in a single hospital in

Maryland found that, in the year after expansion, there was a small but statistically significant reduction in the proportion of ED patients that were high utilizers and a reduction in visits to the ED for ambulatory care sensitive conditions. However, high utilizers remained more likely than low utilizers to have ED visits for ambulatory care sensitive conditions before and after Medicaid expansion.[201,202,203]

  - Two studies found that Medicaid expansion was associated with declines in hospital length-of-stay for Medicaid patients. Another analysis found that, contrary to past studies associating Medicaid insurance with longer hospitalizations 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 general medicine patients at academic medical centers.[204,205,206]

- 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.[207,208,209,210,211]

- A few studies did not find significant positive effects of expansion on certain measures of access or utilization. For several of the earlier studies in this group, these results may reflect the additional time needed for persons to enroll in Medicaid and establish care following initial expansion implementation. Authors of 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.[212,213,214,215,216,217]

- While some research indicates that provider shortages are a challenge in certain contexts, many studies show that providers have expanded capacity and are meeting increased demands for care.[218,219,220,221,222,223,224,225,226,227,228,229,230,231,232,233,234,235,236,237] For example:

  - One study found that Medicaid expansion was associated with longer wait times for appointments, suggesting remaining access challenges despite improvements in coverage and access measures.[238]

  - In contrast, another study found that Medicaid primary care appointment availability increased significantly in the five expansion states included in the analysis, whereas there were no significant changes in appointment availability in the non-expansion states studied.[239]

  - An additional 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.[240]

Affordability and Financial Security

Research suggests that Medicaid expansion improves the affordability of care and financial security among the low-income population.

- Several studies show that expansion states have experienced greater reductions in unmet medical need because of cost than non-expansion states. Although a few studies did not identify statistically significant differences in changes in unmet medical need due to cost between expansion and non-expansion states, some of these findings may have been affected by study design or data limitations.[241,242,243,244,245,246,247,248,249,250,251,252,253,254,255,256,257,258]

- Research suggests that Medicaid expansion results in significant reductions in out-of-pocket medical spending. 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. The January 2018 study noted above that focused on the 100-138% FPL population in expansion and non-expansion states also found that Medicaid expansion coverage produced far greater reductions than subsidized Marketplace coverage in average total out-of-pocket spending, average out-of-pocket premium spending, and average cost-sharing spending.[259,260,261,262,263]

- Multiple studies found larger declines in trouble paying as well as worry about paying future medical bills in expansion states relative to non-expansion states.[264,265,266,267,268,269,270,271,272,273,274,275] For example:

    - One study found that, among those residing in areas with high shares of low-income, uninsured individuals, Medicaid expansion significantly reduced the number of unpaid bills and the amount of debt sent to third-party collection agencies. Similarly, other studies have found that Medicaid expansion has significantly reduced the percentage of people with medical debt, reduced the average size of medical debt, reduced the average number of collections, improved credit scores, reduced the probability of having one or more medical bills go to collections in the past 6 months, and reduced the probability of a new bankruptcy filing, among other improvements in measures of financial security.[276,277,278,279]

    - A study of Ohio's Medicaid expansion found that the percentage of expansion enrollees with medical debt fell by nearly half since enrolling in Medicaid (55.8% had debt prior to enrollment, 30.8% had debt at the time of the study).[280]

Self-Reported Health and Health Outcomes

Continually emerging research has documented improvements in self-reported health and certain health outcomes measures following Medicaid expansion.

- Multiple studies have found improvements in measures of self-reported health following Medicaid expansions, and additional research has documented provider reports of newly eligible adults receiving life-saving or life-changing treatments that they could not obtain prior to expansion.[281,282,283,284,285,286]

- One 2017 study found that Medicaid expansion was associated with improved health outcomes for cardiac surgery patients, including a significant decrease in predicted preoperative risk of morbidity or mortality and a decreased risk-adjusted rate of postoperative major morbidity.[287]
- A January 2018 study suggests that expansion may contribute to infant mortality rate reductions. While the mean infant mortality rate rose slightly in non-expansion states between 2014 and 2016, it declined in expansion states over that period. This effect was particularly pronounced among the African-American population.[288]
- A 2018 study found no evidence of expansion affecting drug-related overdoses or fatal alcohol poisonings.[289]
- Four analyses did not find significant changes in self-reported health status. 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.[290,291,292,293]

Economic Effects

State Budgets and Economies

Analyses find positive effects of expansion on multiple economic outcomes, 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 to 90% for 2020 and subsequent years).

- National, multi-state, and single state studies show that states expanding Medicaid under the ACA have realized budget savings, revenue gains, and overall economic growth. A 2016 study found that growth in state Medicaid spending in expansion states has been lower relative to non-expansion states, but an uptick was predicted for state fiscal year (SFY) 2017, primarily due to the phase-down in the federal share for the expansion population from 100% to 95% in 2017. As of the end of Summer 2016, several expansion states planned to use provider taxes or fees to fund all or part of the state share of expansion costs beginning in 2017. While studies showed higher growth rates in total Medicaid spending (federal, state, and local) following initial expansion implementation in 2014 and 2015, this growth rate slowed significantly in 2016.[294,295,296,297,298,299,300,301,302,303,304,305,306]
    - 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.[307]
    - A Louisiana annual report on Medicaid expansion reported 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.[308]

- Multiple studies suggest that Medicaid expansion can result in state savings by offsetting state costs in other areas, including state costs related to behavioral health services, crime and the criminal justice system, and Supplemental Security Income program costs. 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.[309,310, 311,312,313,314,315,316]

Medicaid Spending Per Enrollee

- National studies have found lower Medicaid spending per enrollee for the new ACA adult eligibility group compared to traditional Medicaid enrollees and that per enrollee costs for newly eligible adults have declined over time since initial implementation of the expansion.[317,318,319]
    - 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.[320]
    - 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.[321]
    - The 2016 Actuarial Report on the Financial Outlook for Medicaid shows that while the average per enrollee costs for newly eligible adults in initial years following expansion were higher than for previously eligible adults, these per enrollee costs have declined over time as states have adjusted capitation rates to better reflect actual use. By 2018, the cost for newly eligible adults is projected to be less than that of previously eligible adults.[322]

Marketplace Effects

- Research suggests that Medicaid expansion may contribute to lower Marketplace premiums—one study found that Marketplace premiums are about 7% lower in expansion compared to non-expansion states. The study authors suggested that the difference in premiums reflects a difference in risk pool between expansion and non-expansion states, where individuals between 100 and 138% FPL make up a greater share of Marketplace enrollment in non-expansion compared to expansion states. 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).[323,324,325]
    - 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.[326,327]

Impacts on Hospitals and Other Providers

Medicaid expansion results in reductions in uncompensated care costs for hospitals, clinics, and other providers.

- Research shows that Medicaid expansions result in reductions in uninsured hospital 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.[328,329,330,331,332,333,334,335,336,337,338,339,340,341,342,343,344,345,346,347,348,349,350,351,352,353,354,355,356,357,358,359,360,361,362,363,364]
    - Some studies point to improvements in patterns of use of emergency departments (EDs), specifically. Two recent single-state studies in Maryland and Illinois, a study comparing California to Florida (a non-expansion state), and a study across 25 expansion and non-expansion states, found significant declines in uninsured ED visits and increases in Medicaid-covered ED visits following expansion implementation (the studies that included non-expansion states found much smaller changes on these measures in the non-expansion states). [365,366,367,368]
    - One study found that expansion significantly increased Medicaid coverage of treatment at specialty substance use disorder (SUD) treatment facilities and decreased the probability that patients at these facilities were uninsured. A second 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.[369,370]
    - Evidence suggests that Medicaid expansion significantly reduced variation in provision of uncompensated care between hospitals that treat a disproportionate share of low-income patients (DSH hospitals) and those that do not, with DSH hospitals experiencing significantly larger reductions in uncompensated care days per bed.[371]
- A new 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.[372]
- Additional studies demonstrate that Medicaid expansion has significantly improved hospital operating margins. One analysis found that while all types of hospitals in expansion states experienced reductions in uncompensated care costs and increases in Medicaid revenue

compared with their counterparts in non-expansion states, 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.[373,374,375,376]

Employment and Labor Market Effects

Studies find that Medicaid expansion has had positive or neutral effects on employment and the labor market.

- State-specific studies have documented or predicted significant job growth resulting from expansion. A study in Colorado found that the state supports 31,074 additional jobs due to Medicaid expansion as of FY 2015-2016, and a study in Kentucky estimated that expansion would create over 40,000 jobs in the state through SFY 2021 with an average salary of $41,000.[377,378,379]
- No studies have found negative effects of expansion on employment or employee behavior. Studies examining employment rates and other measures such as transitions from employment to non-employment, the rate of job switches, transitions from full- to part-time employment, labor force participation, and usual hours worked per week have not found significant effects of Medicaid expansion. One study showed that adults with disabilities living in expansion states are significantly more likely to be employed and less likely to be unemployed due to disability compared to adults with disabilities in non-expansion states.[380,381,382,383,384]
- In an analysis of Medicaid expansion in Ohio, most expansion enrollees who were unemployed but looking for work reported that Medicaid enrollment made it easier to seek employment. Over half of expansion enrollees who were employed reported that Medicaid enrollment made it easier to continue working.[385]
- One 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.[386]
- An additional analysis found that Medicaid expansion is associated with increased responsiveness of the program to meet coverage needs during periods of high unemployment.[387]

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 to care, utilization, and affordability; and economic outcomes, including impacts on state budgets, uncompensated care costs for hospitals and clinics, and employment and the labor market. However, findings on provider capacity are mixed, with some studies suggesting that provider shortages are a challenge in certain contexts. 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.

While future research will be necessary to study the effects of new waiver provisions recently approved by or pending approval from the Trump administration, findings from this literature review on states with existing expansion waivers (such as Indiana) suggest that adding new restrictions or program complexities to Medicaid through Section 1115 waivers could compromise coverage and access gains achieved under expansion or slow future progress. Key questions for future consideration include whether increased flexibility under Section 1115 waiver authority will result in roll-backs in coverage, whether additional states will adopt the expansion and under what conditions, and how new Medicaid expansion-related restrictions and requirements will impact states, beneficiaries, and providers. We will continue to monitor and update this literature review 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.

Endnotes

[1] This is an update to three earlier versions of this issue brief that covered studies published through May 2016, January 2017, and June 2017.

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[8] George Wehby and Wei Lyu, "The Impact of the ACA Medicaid Expansions on Health Insurance Coverage through 2015 and Coverage Disparities by Age, Race/Ethnicity, and Gender" *Health Services Research* epub ahead of print (May 2017), http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12711/abstract

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