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Medi-Cal Expansion and Children's Well-Being



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SUMMARY

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A Technical appendix to this report is available on the PPIC website.

Under the federal Affordable Care Act (ACA), California expanded eligibility for Medi-Cal, the state’s Medicaid program, to most non-elderly, non-disabled low-income adults. Although this change focused directly on improving the health and well-being of adults, it is likely that Medi-Cal expansion has had a dramatic effect on households with children.

In recent years, as the federal government has attempted to dismantle the ACA, California policymakers have continued to push forward with efforts to protect and expand coverage gains. A better understanding of the impact of adult Medi-Cal on child well-being can help inform state efforts to expand health care coverage and improve outcomes for low-income children and families.

In this report, we describe trends in health insurance coverage for California children and the adults they live and interact with. We also summarize recent research on the effects of Medicaid expansion for participating states on two broad areas that are particularly important for family well-being: financial security and behavioral health—including the prevention and treatment of mental health issues and substance use disorder. Key findings include:

- Uninsured rates among California’s low-income children have declined by more than 60 percent since the ACA coverage expansion. The share of children living with uninsured parents or other adults in their household also declined substantially.
- Despite these coverage gains, about 20 percent of low-income children continue to live with an uninsured parent. Among low-income children in households headed by non-citizen Latinos, these shares are substantially higher, with more than 40 percent continuing to live with an uninsured parent.
- There is strong evidence from national research that Medicaid expansion improved adults’ financial and behavioral health. Medicaid participants experienced fewer negative financial shocks such as “catastrophic” medical expenses, bills in collection, bankruptcy, and evictions. Broader financial health indicators, such as credit scores, also improved.
- In the area of behavioral health, research finds a reduction in depression symptoms. Medicaid covers the cost of additional behavioral-health-related prescription drugs and treatment, including medications for depression and opioid use disorder.

Given the longstanding associations of adult financial security, mental well-being, and the absence of addiction with positive child outcomes, it is likely

that children are benefitting from the ACA's Medicaid expansion. The national research is promising, but it is important to determine whether California's Medi-Cal expansion is indeed leading to improvements in child mental health and welfare. In California, Latinos and non-citizens are especially likely to be uninsured, making it important to look at the distribution of improvements across the state's population. As state policymakers seek to protect coverage gains while exploring options to expand insurance coverage to all Californians, a full assessment of the potential benefits of the Medi-Cal program is critical.

Introduction

Medi-Cal, California’s Medicaid program, has long provided health insurance to low-income children and their parents, as well as low-income seniors, people with disabilities, and pregnant individuals. The Affordable Care Act (ACA) offered states the option of extending Medicaid eligibility to almost all low-income adults. California’s decision to embrace the ACA and expand Medi-Cal has drastically changed its health insurance coverage landscape. The expansion was fully implemented in 2014, and the uninsured rate among California’s low-income population has been cut by more than half, to less than 12 percent in recent years.¹ Medi-Cal caseloads have increased by more than 50 percent and nearly one-third of Californians now have health insurance through the program (McConville 2019).

California policymakers are pushing forward with efforts to protect and expand on these coverage gains. In addition, Governor Newsom has made improving child well-being and the lives of low-income families a high priority. His first state budget includes many new investments in “two generation” policies—which target families and parents in order to improve the lives of low-income children. One example is prioritizing preschool access, which improves child development while making it possible for parents to work. California’s Medi-Cal expansion is not often framed in this way. However, the large increases in Medi-Cal coverage, combined with growing evidence that the program’s impact goes beyond improving access to health services, suggest that it is positively affecting California’s children.

Although many low-income parents and children were eligible for Medicaid before the ACA, it is likely that both groups have benefited from the adult Medi-Cal expansion.² It raised the income cap for eligibility to 138 percent of the federal poverty level (FPL), while still requiring satisfactory immigration status (usually in the form of a “green card”). In addition, the ACA included several provisions that encouraged all eligible individuals to enroll in the program.³ As a result, many adults and children who had previously been eligible enrolled in Medi-Cal along with newly eligible adults.

Children interact and live with a range of adults who gained coverage through the Medi-Cal expansion, including non-custodial parents, romantic partners of parents, or housemates. For example, about 37 percent of young children in California live in complex households that include other adults beyond a child’s parent or parents (Danielson and Thorman 2019). To the extent that both non-custodial parents and adult members of a child’s household make financial contributions and help shape the home environment, the impact of health insurance on their financial circumstances and health could improve key childhood outcomes.

This report provides a fuller picture of the impact of Medi-Cal expansion in California and its possible effects on child well-being. We begin with a look at increased coverage rates for children as well as their parents and other adults in their households. We then examine how coverage gains vary across race, ethnicity, and nativity, with a particular focus on Latino and immigrant households, which continue to have lower rates of health insurance coverage compared to other groups. Next, we summarize national research on the impact of Medicaid expansion on adults’ financial security and behavioral health and discuss how these changes could improve child well-being outcomes. We focus predominantly on studies with strong causal findings that are important for California policy;

¹ In this report, we define low-income as having family income under 200 percent of the federal poverty level (FPL). For a family of four in 2019, this would be a maximum income of \$51,500.

² Before the expansion, California allowed parents to participate in Medi-Cal if they had incomes up to 106 percent of the federal poverty level (FPL) if they were working, or 100 percent of FPL if they were jobless (Heberlein et al. 2013). They also needed to be citizens or have satisfactory immigration status, which usually means having a “green card.”

³ ACA provisions that would encourage those previously eligible to enroll include the individual mandate, simplifications to the enrollment process and eligibility determination, the extensive outreach/information campaigns that accompanied the roll out of the coverage expansions, and general reductions in stigma associated with the program.

many of these studies are national in scope. While improvements in adult financial and mental health could affect a wide range of child outcomes, we limit our attention to mental health and child welfare. Unlike other areas such as educational performance, criminal justice involvement, or later employment, mental health and child welfare are meaningful for children of all ages. They are also likely to show improvements in the early years following Medi-Cal expansion, whereas other effects could take time to materialize. We conclude with a discussion of the implications of these findings for California.

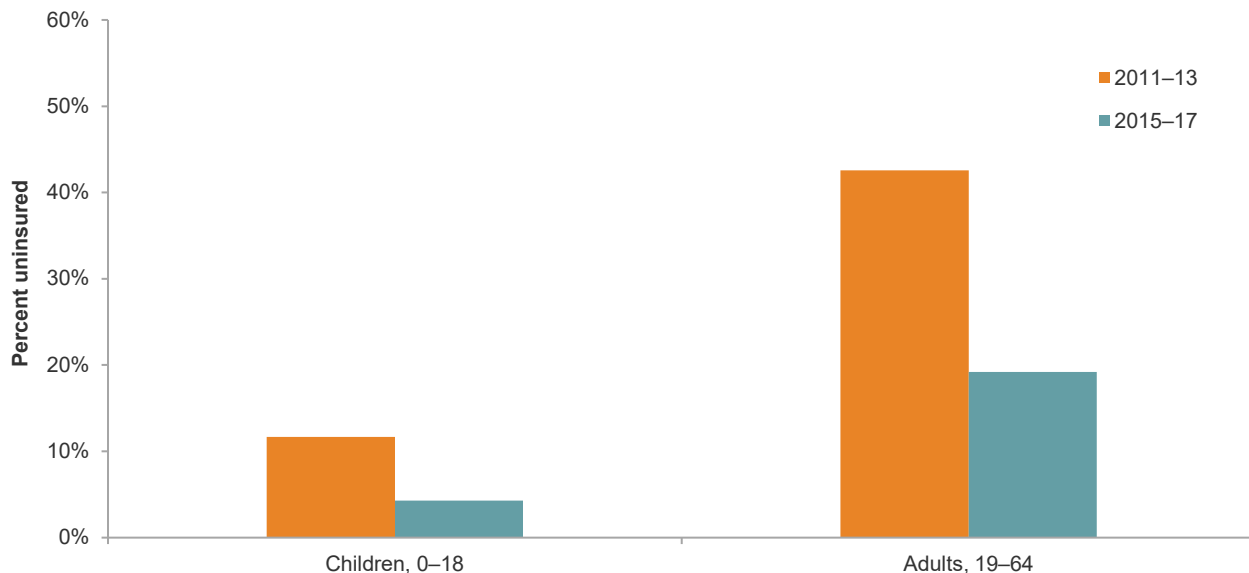
Uninsured Rates for California Families Declined Dramatically

The ACA Medi-Cal expansion in California extended eligibility broadly to all adults up to 138 percent of FPL. Children did not see eligibility changes, but they also experienced dramatic declines in uninsured rates after the policy was implemented in 2014 (Figure 1).

The uninsured rate for low-income Californians under age 19 declined from 11.7 percent in the years immediately before expansion (2011–13) to 4.3 percent in the most recent years of data available after expansion (2015–17), which represents a 63 percent reduction. A similar spike in enrollment, often called the “welcome mat” or “woodwork” effect, occurred across Medicaid expansion states (Hudson and Moriya 2017; Frean, Gruber, and Sommers 2017). The welcome-mat effect has also been documented after past expansions to low-income adults (DeVoe et al. 2015; Dubay and Kenney 2003).

FIGURE 1

Uninsured rates among California’s low-income children and non-elderly adults have declined dramatically



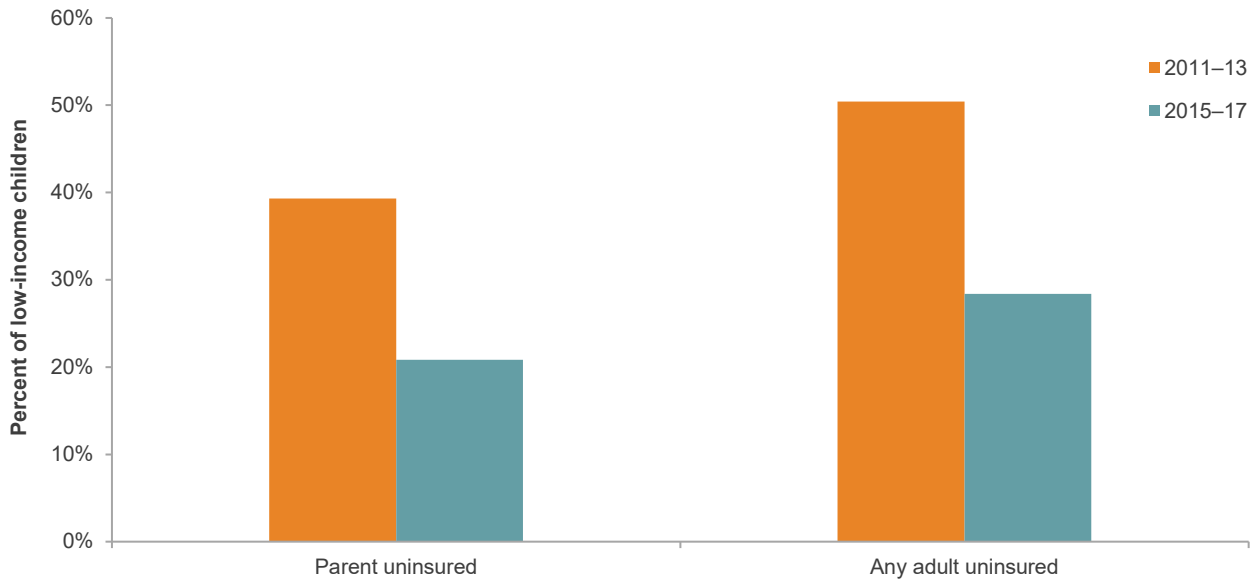
SOURCE: American Community Survey (ACS), 1-year Public Use Microdata Sample, 2011–13 and 2015–17.

NOTES: Uninsured rates are averaged for the three-year period before Medi-Cal expansion (2011–13) and for the most recent three years of data (2015–17). Uninsured rate in the ACS refers to whether the person had any insurance coverage at the time of the survey. Low-income is defined as family income below 200 percent of the official federal poverty level.

In the years prior to the ACA Medi-Cal expansion, about 40 percent of California’s low-income children lived with an uninsured parent and about half lived with an uninsured adult (Figure 2). By 2017, these shares were cut in half: about 20 percent of low-income children lived with an uninsured parent and about 28 percent lived with an uninsured adult.

FIGURE 2

The share of California’s low-income children living with an uninsured parent or adult has dropped



SOURCE: American Community Survey, 1-year Public Use Microdata Sample, 2011–13 and 2015–17.

NOTES: Figure shows percent of low-income California children in a household with a mother and/or father or any adult age 19 to 64 who does not have health insurance. Parents who do not live with their children are not included. Other adults in the household may or may not be related to the child. Low-income is defined as family income below 200 percent of the official federal poverty level.

Past Medicaid Expansions to Parents Improved Children’s Health Insurance Coverage and Access to Care

Earlier Medicaid expansions among adults have been shown to improve children’s health and access to care (Davidoff et al. 2003). Providing health insurance to adults can help children stay enrolled in Medi-Cal and remain connected to health services. Past research shows that having a family member such as a parent enrolled in public health insurance is associated with lower dropout from public coverage among children (Sommers 2006). ACA-related gains in Medi-Cal coverage among parents are thus likely to help the children they live with stay connected to Medi-Cal.

Low-income pregnant women were eligible for Medicaid or other public health insurance programs in all states prior to the ACA (Marks 2010; Heberlein et al. 2013). The ACA Medicaid expansion did not target pregnant women or parents of young children and did not significantly improve birth outcomes overall, although it did help reduce disparities between black and white infants in expansion states (C. Brown et al. 2019). A study of some eligibility expansions to parents found that parental enrollment in Medicaid increased the likelihood that children receive a well-child visit (Venkataramani, Pollack, and Roberts 2017). Research on earlier expansions of Medicaid to pregnant women and parents found that these policies increased prenatal care use (Wherry 2018) and reduced poor birth outcomes such as low birth weight and infant mortality (Currie and Gruber 1996; Currie and Grogger 2002).

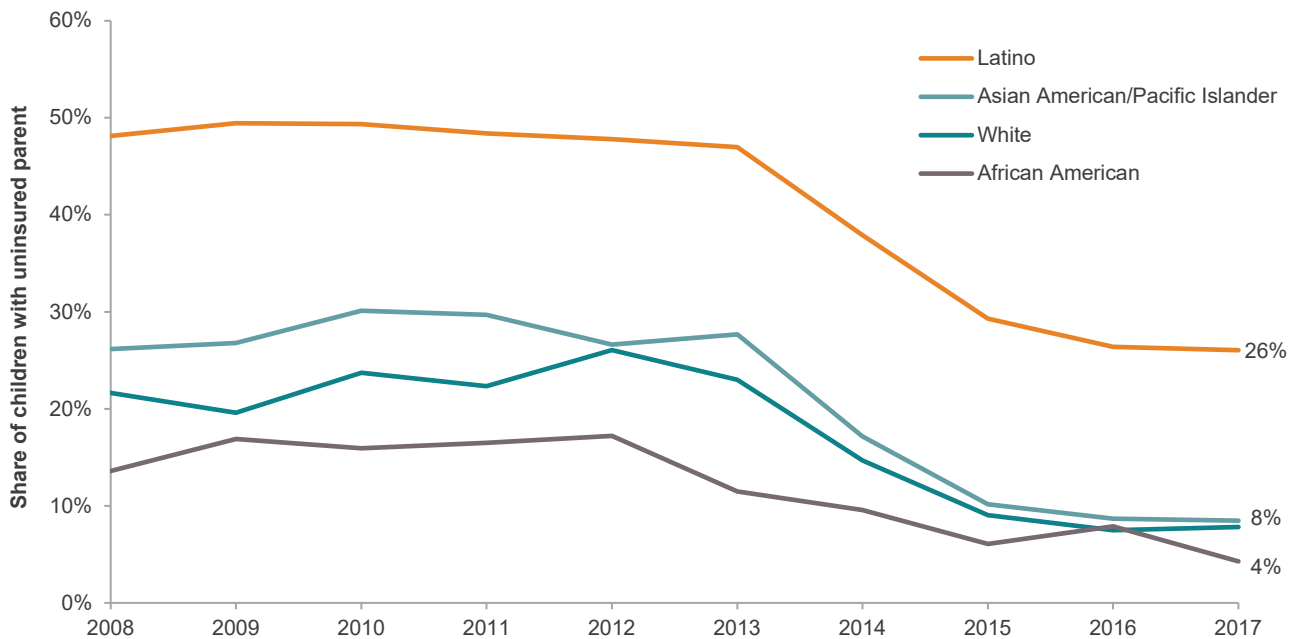
Coverage Gains Have Been Unevenly Distributed

Disparities in health insurance coverage based on race, ethnicity, nativity, and citizenship status make it likely that the potential positive effects of adult coverage gains on children are not evenly distributed across all demographic groups.

In line with national trends, California saw reduced disparities in insurance coverage across racial/ethnic groups after it expanded Medi-Cal. However, there continue to be clear racial/ethnic differences in the share of children living with uninsured parents since the expansion (Figure 3). Among children who live in households headed by Latinos, 26 percent continue to live with an uninsured parent in 2017 and about 35 percent live with at least one uninsured adult.⁴ This compares to only about 8 percent of low-income children in white or Asian American/Pacific Islander households living with an uninsured parent and about 4 percent of low-income children in African American households.

FIGURE 3

Low-income children in Latino households remain much more likely to live with uninsured parents



SOURCE: American Community Survey, 1-year Public Use Microdata Sample, 2008–2017.

NOTES: Figure shows race and ethnicity of heads of household. Parents who do not live with their children are not included. Low-income is defined as family income below 200 percent of the official federal poverty level.

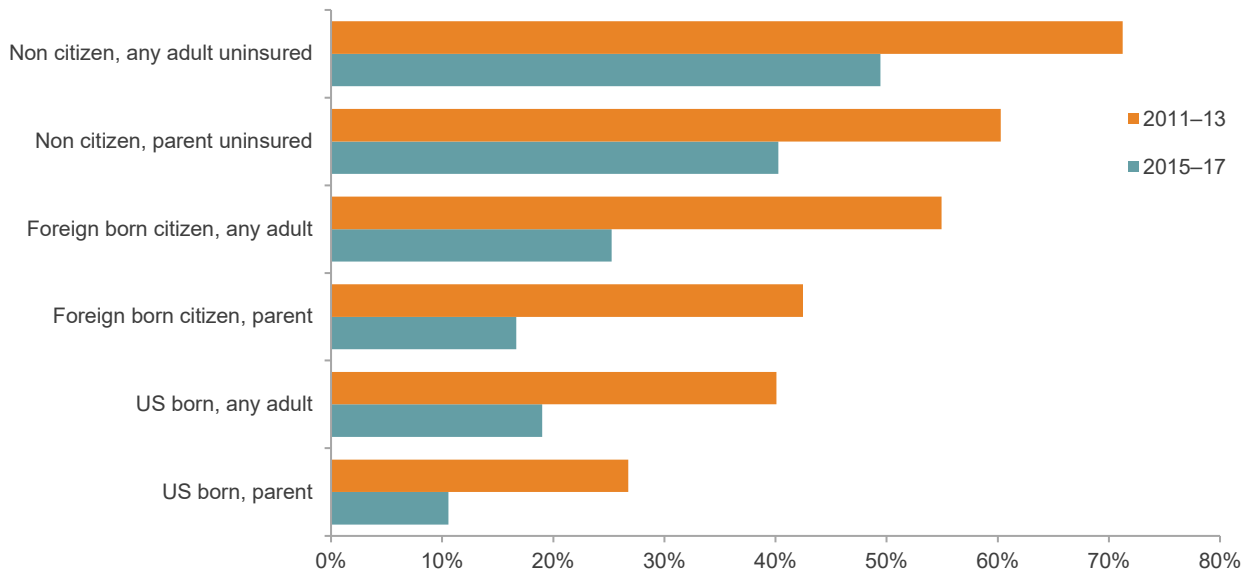
The large disparity for low-income Latino children is driven by nativity and citizenship status. Low-income children with US-born Latino heads of household are slightly more likely than children of other races/ethnicities to have an uninsured parent (about 11%, compared to about 8%). But when we consider low-income children who have a non-citizen Latino as head of household, we see that despite relatively large declines after the ACA, about 40 percent continue to live with an uninsured parent, and half live with at least one uninsured adult (Figure 4). This is especially concerning given that about half of low-income children in

⁴ Data on race, ethnicity, and nativity are based on head of household characteristics throughout this report.

California live in households headed by a non-citizen Latino. While all foreign-born and non-citizen households with children have higher uninsured rates among adults relative to their US-born counterparts, lack of insurance coverage is clearly driven by Latino households.

FIGURE 4

Uninsured rates have fallen under the ACA, but half of low-income children in households headed by non-citizen Latinos still live with an uninsured adult



SOURCE: American Community Survey, 1-year Public Use Microdata Sample, 2011-2013 and 2015-2017.

NOTES: Figure shows nativity and citizenship of heads of household. Figure shows percent of low-income California children who live with a Latino head of household. Parents who do not live with their children are not included. Other adults in the household may or may not be related to the child. Low-income is defined as family income below 200 percent of the official federal poverty level.

These trends are perhaps not surprising, considering that undocumented immigrants were largely excluded from coverage expansions under the ACA.⁵ Undocumented adults constitute the largest population that continues to be uninsured in California. Also, federal immigration policies and rhetoric may be deterring many immigrants from enrolling in public programs even when they are eligible. This effect may be intensified by a recent change to the federal government’s public charge rule, which determines whether an immigrant is at risk of becoming dependent on government assistance.⁶ The rule now includes Medi-Cal participation (or risk of future participation) as a negative factor for immigrants seeking admittance or green cards.

There is evidence that disparities in coverage and access to care were reduced nationwide as a result of the ACA expansions. In general, Latinos saw large gains in coverage, but because their baseline uninsured rates were so much higher those for than other groups, gaps persist (Buchmueller et al. 2016; Wehby and Lyu 2018). However, other research suggests Latinos may not have seen improvements on par with other racial or ethnic groups (Yue, Rasmussen, and Ponce 2018). Non-citizens also saw significant declines in uninsured rates nationally, but they still are more likely than their US-born counterparts to lack coverage (Stimpson and Wilson 2018).

⁵ It is important to note that we are not able to identify undocumented immigrants among the non-citizen population. According to available estimates, the numbers of undocumented Californians has declined in recent years (Johnson and Sanchez 2019).

⁶ In October 2019, several federal courts blocked the implementation of the new public charge rule. There is a chance the rule will never be implemented, but community organizations report that negative effects on immigrant participation in safety net programs are already occurring.

Medicaid's Effects on Adults May Also Benefit Children

There is a large and growing evidence base on the effects of the ACA Medicaid expansion on a wide range of outcomes. The ACA Medicaid expansion has been linked to improvements in health insurance coverage, access to care and prescription drugs, and—to a limited extent—health outcomes. We are still in the early years of expanded coverage, and future research will demonstrate whether additional improvements emerge over time. We limit our scope here to two areas in which well-documented short-term changes are likely to have large effects on overall family well-being: financial security and behavioral health. Table 1 and Table 2 summarize the main findings of our review.

Literature review

We conducted a literature review of high-quality research on the effects of Medicaid or state health insurance expansions to low-income adults on financial security and behavioral health. We performed keyword searches and reviewed more than 80 articles published in peer-reviewed journals, as well as select research reports that may not have undergone peer review. We restricted our review to studies with credible causal findings. In doing this, we excluded a great many studies that limited their scope to documenting associations between Medicaid and other outcomes.

Because some states expanded Medicaid under the ACA and others did not, researchers have been able to deploy analytic methods that generate causal evidence of effects. Most evidence in our review comes from the ACA Medicaid expansion, or state expansions such as the Oregon Health Insurance Experiment or Massachusetts health reform. For more details on the literature review and specific studies, see the [Technical Appendix](#).

Medicaid Improves the Finances and Behavioral Health of Low-Income Adults

There is clear evidence that Medicaid improves the finances of low-income adults. Specific improvements include decreases in health-related spending such as co-pays and premiums, protection against financial shocks like “catastrophic” medical spending, reductions in overall debt, and fewer bankruptcy filings and evictions (Table 1) (Blavin et al. 2018; Brevoort, Grodzicki, and Hackmann 2017; Caswell and Waidmann 2017; Glied, Chakraborty, and Russo 2017; Golberstein, Gonzales, and Sommers 2015; Hu et al. 2018; Mazumder and Miller 2016; McMorroo et al. 2017; Zewde and Wimer 2019; Allen et al. 2019). The program also reduces poverty and increases financial stability through better credit scores (Brevoort, Grodzicki, and Hackmann 2017; Caswell and Waidmann 2017; Mazumder and Miller 2016; Zewde and Wimer 2019).

TABLE 1
Evidence on Medicaid’s effects on financial security

Financial security outcome	Key findings
Medical-related expenses	Decreased financial barriers to health care Reduced spending on health insurance premiums and copays
Negative financial shocks and debt	Decreased likelihood of “catastrophic” medical expenses Reduced medical and non-medical debt Decreased likelihood of housing eviction Declines in debt and less debt past-due Fewer bills in collections Reductions in bankruptcy filings
Credit scores and future financial opportunities	Reduction in poverty Improved credit scores Access to credit at lower interest rates, including car loans and mortgages

SOURCES: Research papers primarily from the peer-reviewed literature; see the [Technical Appendix](#) for details.

NOTE: This table summarizes studies that use an experimental or quasi-experimental research design to determine the causal effects of Medicaid or other public health insurance expansion affecting low-income adults on financial security.

The expansion of Medicaid in California and other participating states led to more adults with mental health issues or substance use disorders gaining insurance coverage (Fry and Sommers 2018; Saloner et al. 2017; Olfson et al. 2018). This set the stage for some of the positive behavioral health findings produced by the expansion. The strongest evidence pertains to self-reported mental health (Table 2). Medicaid coverage reduces depression and psychological distress (Baicker et al. 2018; Finkelstein et al. 2012; McMorroo et al. 2016; 2017). There are mixed findings on access to mental health services, but studies from an experimental evaluation called the Oregon Health Insurance Experiment are especially credible, and they consistently find that Medicaid access increases diagnoses of depression, increases prescriptions for mental health medications, and reduces rates of untreated depression (Baicker et al. 2017; Baicker et al. 2018).

TABLE 2

Evidence on Medicaid’s effects on behavioral health

Mental health outcome	Key findings
Specific mental health issues	Reduced self-reported depression and poor mental health days Reduced psychological distress
Access to mental health services	Increased official diagnoses of depression (mixed evidence) Increased utilization of mental health services (mixed evidence) Increased prescriptions for mental health issues, primarily for depression
Substance use disorder outcome	Key findings
Access to treatment for substance use disorder	Increased access to opioid use disorder treatment, but no change for <i>general</i> substance use disorder treatment Increased prescriptions for medication used to treat opioid use disorder
Supply of substance use disorder treatment providers	No change in overall supply or capacity of treatment facilities More physicians able to prescribe medication used to treat opioid use disorder
Payer source for substance use disorder treatment	Increased role of Medicaid in paying for inpatient and outpatient substance use disorder treatment Medicaid replaced local or other public sources, but not private insurance

SOURCES: Research papers primarily from the peer-reviewed literature; see the [Technical Appendix](#) for details.

NOTE: This table summarizes studies that use an experimental or quasi-experimental research design to determine the causal effects of Medicaid or other public health insurance expansion affecting low-income adults on behavioral health.

Among the strongest findings related to substance use disorder is that Medicaid expansion boosted the program’s role as a payer for substance use disorder treatment (Andrews et al. 2019; Maclean and Saloner 2019; Meinhofer and Witman 2018). Findings on access to care for substance use disorder are mixed. Medicaid increased access to treatment for opioid use disorder but not to substance use disorder treatment in general (Maclean and Saloner 2019; Meinhofer and Witman 2018; Olfson et al. 2018; Saloner et al. 2018). Some of this may be due to the fact that while more physicians received waivers to prescribe medication for opioid use disorder, treatment center capacity did not increase (Andrews et al. 2019; Meinhofer and Witman 2018; Wen et al. 2017).

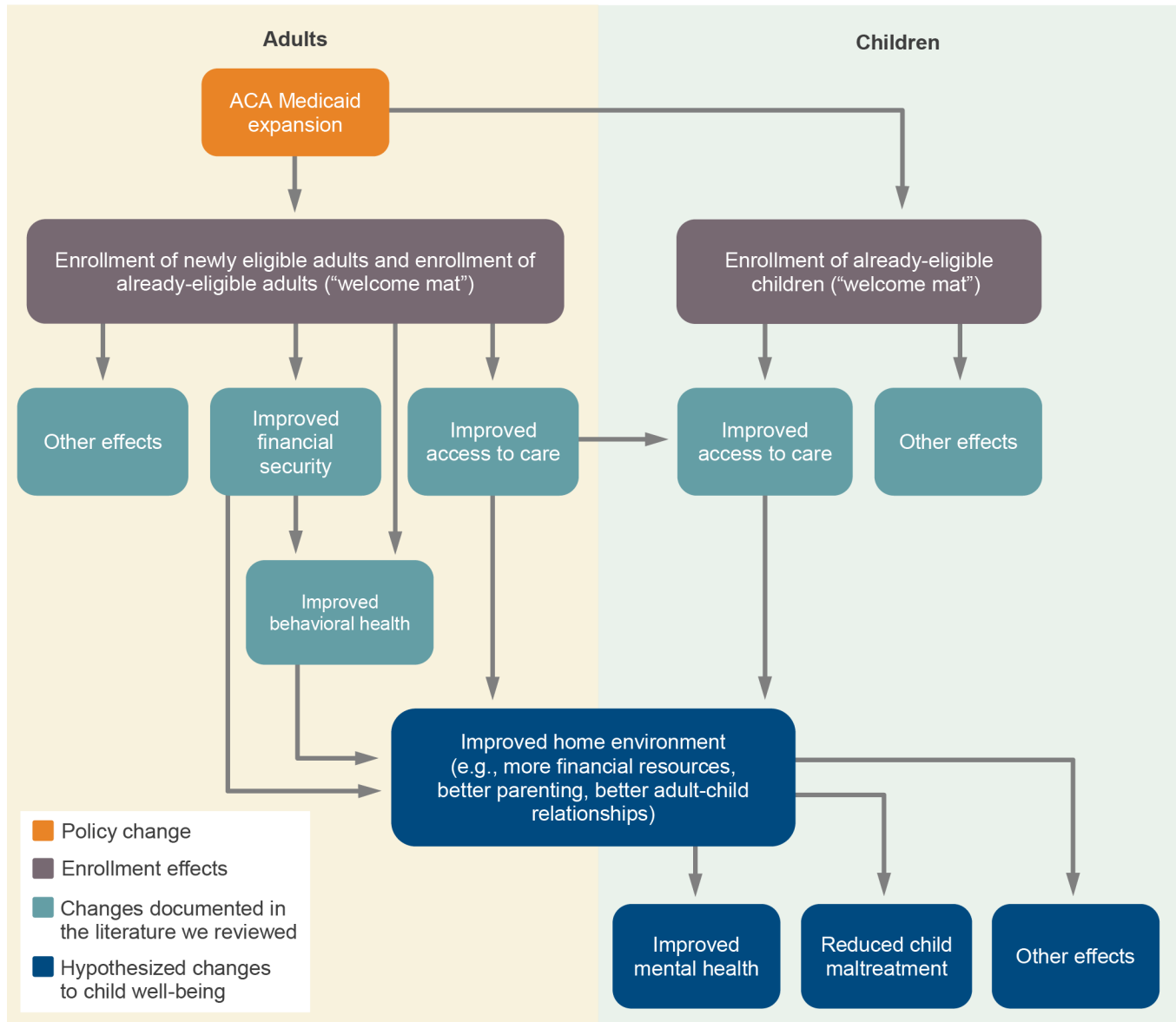
These Changes Could Improve Child Well-Being

Reduced financial strain, greater future financial opportunity, better mental health, and increased access to treatment for opioid use disorder are likely to improve home environments, including parenting and household finances, which could positively affect children. As we explained above, our focus is on short-term outcomes that are meaningful for children of all ages. In addition, children’s mental health is a growing national concern, with rates of anxiety and depression increasing in recent years (Ghandour et al. 2019). In 2017, a California survey found that 6.4 percent of California adolescents had experienced psychological distress within the previous month (California Health Interview Survey 2017). Child welfare outcomes are also priorities for policymakers and child advocates due to the many negative effects of significant maltreatment and consequent involvement in the child welfare system. Nearly half a million of the state’s 9.2 million children were alleged to be victims of abuse or neglect in 2018 (Webster et al. 2019). Fortunately, only 14 percent of those reports were substantiated, and only 27,800 children entered the foster care system during this period (Webster et al. 2019).

Figure 5 maps the flow of the ACA Medicaid expansion to financial security and behavioral health outcomes among adults and to possible improvements in children’s well-being.

FIGURE 5

Potential pathways and mechanisms for ACA Medicaid expansion to improve child well-being



SOURCE: Multiple studies (see the [Technical Appendix](#) for details).

Increased financial security could allow adults to invest more resources in children and lead to improved parenting. Increased financial resources have been shown to produce a range of improvements for children (Gennetian, Castells, and Morris 2010). Increases in household incomes lead to fewer psychiatric symptoms, better conduct, and improved emotional well-being (Costello et al. 2003; Milligan and Stabile 2011). It is possible that these positive effects are the result of improved mental health among parents (Yeung, Linver, and Brooks-Gunn 2002). In the case of Medicaid expansion, the program’s positive effects on adult mental health could be

due to improved finances. Having more income is also associated with reduced risk of child maltreatment (Jonson-Reid, Drake, and Kohl 2009; Pelton 2015; Cancian, Yang, and Slack 2013; Raissian and Bullinger 2017).

Decreases in adult depression and increased access to mental health services among adults could improve children's mental health and reduce child maltreatment. Parental depression is a known risk factor for depression in children (Cummings, Keller, and Davies 2005). It is also associated with child physical discipline or abuse (Dubowitz et al. 2011; Shay and Knutson 2008). Improvements to adult mental health due to Medicaid may be the result of gaining health insurance coverage and reducing financial worries rather than mental health treatment. If mental health improvements are not sensitive to treatment quality or intensity, the relationship between improved adult mental health and child well-being could be quite robust.

Improved access to treatment for opioid use disorder under the ACA is likely to contribute to better outcomes for children. Substance use is a known risk factor for child maltreatment (Dubowitz et al. 2011; Ghertner et al. 2018). US counties with higher overdose and drug hospitalization rates have larger child welfare caseloads (Radel et al. 2018). States that expanded their Medicaid programs under the ACA saw the number of neglect cases decline while their non-expansion counterparts saw an increase (E. Brown et al. 2019). While entry into treatment does not necessarily lead to recovery, it is a proxy for individuals' intentions, and parents may have strong incentives to end their addictions (Olfson et al. 2018). Rates of neonatal abstinence syndrome—a group of conditions caused when a baby withdraws from certain drugs they are exposed to in the womb before birth—increased in tandem with the opioid epidemic (Lynch et al. 2018; Smith 2017). Treatment entry during or before pregnancy could result in fewer infants experiencing this syndrome.

Conclusion

By broadening access to health insurance coverage and increasing access to health care, robust national evidence indicates that California's Medi-Cal expansion has improved adult financial and behavioral health. The evidence we have outlined in this report suggests that significant improvements in the financial well-being of low-income families and/or the behavioral health of low-income adults could directly improve child mental health and child welfare. Medi-Cal expansion also improved access to treatment for opioid use disorder, which could improve child welfare by reducing neonatal abstinence syndrome and neglect.

While our review of existing research has yielded promising evidence, it will be important to study whether Medi-Cal does indeed function as a two-generation program, improving the mental health and welfare of children as well as helping adults. We have seen that because Latinos and non-citizens in California are less likely to have health insurance, children in these households are less likely to experience these gains. Recent federal policy changes, including adding potential Medicaid use as a negative consideration in immigrant admissions and green card approvals, may further depress participation in Medi-Cal even among Latinos and non-citizens who are eligible. In future work, we will investigate the ACA expansion's effects on California's children and examine these effects across demographic characteristics such as race, ethnicity, and nativity. A fuller understanding of the impact of coverage expansion can help policymakers weigh the costs and benefits of future program expansions and the longer-range goal of universal coverage.

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