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Medi-Cal Expansion and Children's Well-Being

Technical Appendix

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Review of Literature on Financial Security and Behavioral Health

Our report describes findings from a narrative literature review in the areas of financial security and behavioral health, which includes substance use disorder and mental health. All of the studies in the review analyzed a financial security or behavioral health outcome resulting from Medicaid or another health insurance expansion to low-income adults.¹ Historically, most expansions of Medicaid and other public insurance programs targeted children. Expansions to adults, especially to adults without children, are a more recent phenomenon. Because of this history, and also because we prioritized recent evidence, most of the studies in our review focused on the ACA Medicaid expansion, with additional studies coming from other settings such as the Oregon Health Insurance Experiment and Massachusetts health reform.

We aimed to summarize causal evidence on adult outcomes as a foundation for generating hypotheses regarding child well-being. Associational studies of Medicaid are unlikely to capture a causal effect of the program, since Medicaid eligibility and program enrollment occur only among low-income individuals, and being low-income predicts a wide range of negative outcomes that should not be attributed to the program. Associational studies that compare Medicaid recipients with eligible non-enrollees still lack a comparable control group since there are many unobserved factors that determine enrollment in Medicaid that cannot be controlled for. In the case of the ACA, researchers have relied on the variation in states' Medicaid expansion decisions and timing to conduct controlled quasi-experiments of Medicaid. If certain conditions are met, this approach provides estimates of causal or likely causal effects of the policy change. We focused our review on experiments and quasi-experiments, and excluded any purely associational studies.

Our narrative review included some features of a systematic review. We conducted searches for journal articles and reports in the PubMed database and on the Google Scholar website. The searches used the following words and phrases, plus some of their variants (different suffixes and abbreviations): Medicaid, expansion, Affordable Care Act, mental health, behavioral health, substance use disorder, serious mental illness, serious psychological distress, alcohol use disorder, finance, payment debt, bankruptcy, repossession. In order to be included, the studies needed to meet four criteria: (1) analyze a financial security or behavioral health outcome that is (2) the result of a health insurance expansion to (3) low-income adults using (4) methods that produce plausibly causal estimates. We also included work cited by the search-identified articles, as well as other studies that we encountered in our regular work dealings, if they met our conditions for inclusion.

This appendix contains two parts. Table A1 below summarizes studies published at time of writing in September 2019 that offer the strongest evidence about the effects of Medicaid or other health insurance expansions in the areas of adult behavioral health or financial security. The narrative review that follows summarizes findings for adult financial security and behavioral health. Throughout the review, we emphasize studies with research designs that are able to determine whether ACA Medicaid expansion and state expansions of insurance coverage for low-income adults, although we refer to studies from before the expansion and descriptive findings that provide important context.

¹ For example, California's Low Income Health Program (sometimes called "early ACA Medicaid") and the Massachusetts state health reform.

TABLE A1

Studies on the Effects of Medicaid (or Other Health Insurance) for Low-Income Adults on Financial Security and Behavioral Health

* Abbreviations help connect listed studies to the outcomes column of Table 1 in the main report. MRE is medical-related expenses, NFS is negative financial shocks and debt, CSF is credit scores and future financial opportunities, MH is specific mental health issues, MHS is access to mental health services, STX is access to treatment for substance use disorder, SUP is supply of substance use disorder treatment providers, and PAY is payer source for substance use disorder treatment.

Authors/Journal	Outcomes*	Title	Setting	High-Level Findings	Main Data Source / Method	Selected Details
Financial Security						
Allen, Heidi L., Erica Eliason, Naomi Zewde, and Tal Gross 2019; Health Affairs	NFS	Can Medicaid Expansion Prevent Housing Evictions?	California: Early ACA Medicaid Expansion (Low Income Health Program)	Fewer evictions	Commercial evictions database from American Information Research Services; quasi-experimental (difference-in-differences)	For every 1,000 enrollees in early Medicaid, there were 22 fewer evictions per year.
Blavin, Fredric, Michael Karpman, Genevieve M. Kenney, and Benjamin D. Sommers 2018; Health Affairs	MRE, NFS	Medicaid Versus Marketplace Coverage for Near-Poor Adults: Effects on Out-of-Pocket Spending and Coverage	National: ACA Medicaid Expansion	Lower out-of-pocket spending Lower likelihood of high-burden spending	Current Population Survey and American Community Survey; quasi-experimental (difference-in-differences)	Lower likelihood of having any out-of-pocket spending. Reductions in both types of out-of-pocket spending: premiums and cost-sharing (e.g., copays). Lower likelihood of high-burden (10 percent of income or more) out-of-pocket spending.
Brevoort, Grodzicki, and Hackmann 2017; N/A: National Bureau of Economic Research Working Paper	MRE, NFS, CSF	Medicaid and Financial Health	National: ACA Medicaid Expansion	Reduced medical debt Reduced new delinquencies Improved credit scores More offers of credit Better terms of credit Reduced bankruptcies	Consumer Protection Finance Bureau Consumer Credit Panel data; Mintel data, MyFico; quasi-experimental (difference-in-differences)	Reduction of medical debt estimated to total \$3.4 billion over the first two years of the Medicaid expansion implementation. Types of credit offers that increased include credit cards, personal loans, auto loans, and mortgages. Better terms of credit (lower interest rates) estimated to total \$520 million in annual savings.
Caswell and Waidmann 2017; Medical Care Research and Review	MRE, NFS, CSF	The Affordable Care Act Medicaid Expansions and Personal Finance	National: ACA Medicaid Expansion	Reduced medical debt Reduced proportion of debt past-due Improved credit scores Reduced bankruptcies	Data from one of the three major credit reporting bureaus; quasi-experimental (difference-in-differences and triple-differences)	Reduced the likelihood of any nonmedical collections balance, and reduced the likelihood of having a medical collections balance of at least \$1,000.
Glied, Chakraborty, and Russo 2017; N/A: Commonwealth Fund report	MRE, NFS	How Medicaid Expansion Affected Out-Of-Pocket Health Care Spending for Low-Income Families	National: ACA Medicaid Expansion	Lower out-of-pocket spending Lower likelihood of catastrophic spending	Consumer Expenditure Survey; quasi-experimental (difference-in-differences)	Lower odds of any out-of-pocket medical spending, and reduced spending among those with nonzero spending. Reduced likelihood of catastrophic medical spending (90 th percentile or higher).

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Authors/Journal	Outcomes*	Title	Setting	High-Level Findings	Main Data Source / Method	Selected Details
Golberstein, Gonzales, and Sommers 2015; Health Affairs	MRE, NFS	California's Early ACA Expansion Increased Coverage and Reduced Out-Of-Pocket Spending for the State's Low-Income Population	California: Early ACA Medicaid Expansion (Low Income Health Program)	Lower out-of-pocket spending Lower likelihood of high-burden spending	National Health Interview Survey; quasi-experimental (difference-in-differences)	Reduced the likelihood of having <i>any</i> out-of-pocket spending, and reduced the likelihood of spending at least \$500.
Hu, Luoja, Robert Kaestner, Bhashkar Mazumder, Sarah Miller, and Ashley Wong 2018; Journal of Public Economics	NFS	The Effect of The Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing	National: ACA Medicaid Expansion	Reduced number of bills sent to collections Reduced amount of debt in collections	New York Federal Reserve/Equifax consumer credit panel; quasi-experimental (synthetic control)	Number of bills in collections, and amount of debt in collections were reduced, but other outcomes showed little effect. Credit card balance, balance past due, credit score, total debt (including mortgages), and bankruptcies showed little effect by the end of 2015.
Mazumder, Bhashkar, and Sarah Miller 2016; American Economic Journal: Economic Policy	NFS, CSF	The Effects of the Massachusetts Health Reform on Household Financial Distress	Massachusetts: State Health Reform	Reduced debt Improved credit scores Reduced bankruptcies	New York Federal Reserve consumer credit panel data, Small Area Health Insurance Estimates; quasi-experimental (triple-differences)	The Massachusetts health insurance reform (a precursor to the ACA) improved credit scores, reduced delinquencies, lowered the percent of debt past due, and reduced the incidence of personal bankruptcy.
McMorrow, Stacey, Jason A. Gates, Sharon K. Long, and Genevieve M. Kenney 2017; Health Affairs	MRE	Medicaid Expansion Increased Coverage, Improved Affordability, and Reduced Psychological Distress for Low-income Parents	National: ACA Medicaid Expansion	Increased affordability Reduced worrying about medical costs	National Health Interview Survey; quasi-experimental (difference-in-differences)	Health services affordability increased. Reduced worry about costs were concentrated among mothers.
Zewde, Naomi and Christopher Wimer 2019; Health Affairs	NFS, CSF	Antipoverty Impact of Medicaid Growing with State Expansions Over Time	National: ACA Medicaid Expansion	Reduced poverty rate in expansion states Reduced likelihood of burdensome medical expense	Current Population Survey Annual Social and Economic Supplement; quasi-experimental (difference-in-differences)	The ACA Medicaid expansion pulled an estimated 690,000 individuals out of poverty. The increase in medical costs over time results in a growing antipoverty effect of Medicaid over time. Burdensome levels of medical spending were defined as more than 10 or 20 percent of household resources.
Behavioral Health – Mental Health						
Baicker, Katherine, Heidi L. Allen, Bill J. Wright, and Amy N. Finkelstein 2017; Health Affairs	MHS	The Effect of Medicaid on Medication Use Among Poor Adults: Evidence from Oregon	Oregon: Oregon Health Insurance Experiment	Increased prescriptions for mental health medications	Interview and health assessment data from the Oregon Health Insurance Experiment; randomized control trial	Biggest increases in prescription drugs were medications for mental health (mostly anti-depressants) and diabetes.

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Authors/Journal	Outcomes*	Title	Setting	High-Level Findings	Main Data Source / Method	Selected Details
Baicker, Katherine, Heidi L. Allen, Bill J. Wright, Sarah L. Taubman, and Amy N. Finkelstein 2018; Millbank Quarterly	MHI, MHS	The Effect of Medicaid on Management of Depression: Evidence from the Oregon Health Insurance Experiment	Oregon: Oregon Health Insurance Experiment	<p>Increased diagnoses of depression</p> <p>Decreased prevalence of undiagnosed depression</p> <p>Decreased untreated depression</p> <p>Increased use of anti-depressants</p> <p>Reduced symptoms of depression</p>	Survey, interview, and health assessment data from the Oregon Health Insurance Experiment; randomized control trial	<p>Increased the chances of receiving a depression diagnosis among those without a pre-experiment diagnosis. Also decreased prevalence of undiagnosed depression. Reduced the share with untreated depression (no talk therapy or medication) and virtually eliminated untreated depression among the group with a pre-experiment diagnosis. Increased the use of anti-depressants and reduced the symptoms of depression.</p>
Finkelstein, Amy, Sarah Taubman, Bill Wright, Mira Bernstein, Jonathan Gruber, Joseph P. Newhouse, Heidi Allen, Katherine Baicker, and Oregon Health Study Group 2012; Quarterly Journal of Economics	MHI	The Oregon Health Insurance Experiment: Evidence from the First Year	Oregon: Oregon Health Insurance Experiment	Improved self-reported mental health	Various administrative data sources and survey data from the Oregon Health Insurance Experiment; randomized control trial	Improvements in self-reported mental health were measured as the number of days of good mental health and the number of days not impaired by mental health.
Golberstein and Gonzales 2015; Health Services Research	MHS	The effects of Medicaid eligibility on Mental Health Services and Out-of-Pocket Spending for Mental Health Services	National: Pre-ACA state expansions of Medicaid to low-income adults	No change to use of mental health services	Medical Expenditure Panel Survey-National Health Interview Survey linked data; quasi-experimental (instrumental variables)	No significant increase in use of any mental health services, even when focusing on a population with moderate-to-severe psychological distress. Sample size could be a factor.
McMorrow, Stacey, Genevieve M. Kenney, Sharon K. Long, and Dana E. Goin 2016; Health Services Research	MHI, MHS	Medicaid Expansions from 1997 - 2009 Increased Coverage and Improved Access and Mental Health Outcomes for Low-Income Parents	National: Pre-ACA state expansions of Medicaid to low-income adults	<p>Reduced unmet need for mental health care</p> <p>Reduced psychological distress</p>	National Health Interview Survey; quasi-experimental (instrumental variables)	Reduced unmet need for mental health care due to cost. Reduced psychological distress. Some of the analyses suggested that the immediate mental health benefits could fade over time.
McMorrow, Stacey, Jason A. Gates, Sharon K. Long, and Genevieve M. Kenney 2017; Health Affairs	MHI	Medicaid Expansion Increased Coverage, Improved Affordability, and Reduced Psychological Distress for Low-income Parents	National: ACA Medicaid Expansion	<p>Reduced worrying about medical costs</p> <p>Reduced psychological distress</p>	National Health Interview Survey; quasi-experimental (difference-in-differences)	Reduced worry about costs were concentrated among mothers. Reductions of psychological distress were concentrated among men.

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Authors/Journal	Outcomes*	Title	Setting	High-Level Findings	Main Data Source / Method	Selected Details
Winkelman and Chang 2018; Journal of General Internal Medicine	MHI, MHS	Medicaid Expansion, Mental Health, and Access to Care among Childless Adults with and without Chronic Conditions	National: ACA Medicaid Expansion	Improved self-reported mental health Reduced diagnoses of depression	Behavioral Risk Factor Surveillance System; quasi-experimental (difference-in-differences)	Significantly reduced the reported number of poor mental health days and reduced depression diagnoses. These results were limited to the subgroup of adults with chronic conditions.
Behavioral Health – Substance Use Disorder						
Andrews, Christina M., Harold A. Pollack, Amanda J. Abraham, Colleen M. Grogan, Clifford S. Bersamira, Thomas D'Aunno, and Peter D. Friedmann 2019; Journal of Substance Abuse Treatment	PAY, SUP	Medicaid Coverage in Substance Use Disorder Treatment after the Affordable Care Act	National: ACA Medicaid expansion	Increased role of Medicaid as payer for medication-assisted treatment for substance use disorder No change to supply of substance use treatment programs	National Drug Abuse Treatment System Survey; quasi-experimental (instrumental variables)	Increase in Medicaid-insured patients in outpatient treatment programs with medication-assisted treatment. No evidence that supply or capacity of treatment programs increased.
Maclean and Saloner 2019; Journal of Policy Analysis and Management	STX, PAY	The Effect of Public Insurance Expansions on Substance Use Disorder Treatment: Evidence from the Affordable Care Act	National: ACA Medicaid expansion	No change to admissions to specialty substance use disorder treatment Increased role of Medicaid as payer for specialty substance use disorder treatment	Treatment Episode Data Set and Medicaid State Drug Utilization Data; quasi-experimental (difference-in-differences)	No evidence that Medicaid expansion changed admissions to specialty substance use disorder. Among patients receiving specialty substance use disorder treatment, Medicaid coverage and payments increased.
Meinhofer and Witman 2018; Journal of Health Economics	STX, SUP, PAY	The Role of Health Insurance on Treatment for Opioid Use Disorders: Evidence from the Affordable Care Act Medicaid Expansion	National: ACA Medicaid expansion	Increased admissions to treatment for opioid use disorder Increased role of Medicaid as payer for treatment for opioid use disorder No change to supply of specialty treatment facilities Increased number of physicians with waiver to prescribe buprenorphine	SAMHSA Treatment Episode Data Set Admissions, Automation of Reports and Consolidated Orders System (ARCOS), National Survey of Substance Abuse Treatment Services; quasi-experimental (instrumental variables)	Increased admissions to specialty treatment for opioid use disorder, most of which involved outpatient medication-assisted treatment. Admissions from Medicaid beneficiaries increased. More physicians with waiver to prescribe buprenorphine and increased acceptance of Medicaid by substance abuse disorder providers.

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Authors/Journal	Outcomes*	Title	Setting	High-Level Findings	Main Data Source / Method	Selected Details
Olfson, Mark, Melanie Wall, Colleen L. Barry, Christine Mauro, and Ramin Mojtabai 2018; Health Affairs	STX	Impact Of Medicaid Expansion On Coverage And Treatment Of Low-Income Adults With Substance Use Disorders	National: ACA Medicaid expansion	No change to substance use disorder treatment	National Survey on Drug Use and Health; quasi-experimental (instrumental variables)	No changes to substance use disorder treatment. Authors suggest some population groups such as parents may have more incentives to enter treatment.
Saloner, Brendan, Jonathan Levin, Hsien-Yen Chang, Christopher Jones, and G. Caleb Alexander 2018; JAMA Network Open	STX	Changes in Buprenorphine-Naloxone and Opioid Pain Reliever Prescriptions After the ACA Medicaid Expansion	Selected States: ACA Medicaid Expansion	Increased prescriptions for medication to treat opioid use disorder	IQVIA prescription data; quasi-experimental (instrumental variables)	Buprenorphine-naloxone prescriptions, which are used to treat opioid use disorder, increased.
Wen, Hefei, Jason Hockenberry, Tyrone Borders, and Benjamin Druss 2017; Medical Care	STX, SUP	Impact of Medicaid Expansion on Medicaid-Covered Utilization of Buprenorphine for Opioid Use Disorder Treatment	National: ACA Medicaid expansion	Increased prescriptions for buprenorphine Increased number of physicians with waiver to prescribe buprenorphine	CMS Medicaid Drug Utilization Files; quasi-experimental (instrumental variables)	States that implemented Medicaid expansion saw a 70 percent increase in Medicaid-covered buprenorphine prescriptions and a 50 percent increase in buprenorphine spending. Physician prescribing capacity also significant associated with buprenorphine utilization.

Financial Security Summary

The Medicaid expansion lowered individual payments for health care and lessened the worries and barriers to care associated with those payments. Similar positive effects on family financial security have been shown for past expansions of Medicaid to children (Wherry, Kenney, and Sommers 2016). The ACA expansion to adults reduced self-reported difficulties in accessing health care for financial reasons, or in paying medical bills (Gunja et al. 2017; Long et al. 2017; Shartzter, Long, and Anderson 2016). It also reduced worrying about medical costs, especially among mothers (McMorrow et al. 2017). The Medicaid expansion lowered individuals' costs for health services or prescriptions (Blavin et al. 2018; Glied, Chakraborty, and Russo 2017; Mulcahy, Eibner, and Finegold 2016; Long, Stockley, and Dahlen 2012). Results include reduced likelihood of having to spend any money on health care, and lower amounts paid by those who did spend (Glied, Chakraborty, and Russo 2017). Declines in spending were especially pronounced among those with chronic diseases, who have medical needs that cannot be ignored even when care is costly (Mulcahy, Eibner, and Finegold 2016). These national findings are consistent with evidence from an earlier, county-based ACA health insurance program in California called the Low Income Health Program, which reduced participants' likelihood of having any health spending (Golberstein, Gonzales, and Sommers 2015). They are also consistent with research on older adults, whose health care spending declines when they become eligible for Medicare, a near-universal health insurance program for the elderly (Finkelstein and McKnight 2008; Barcellos and Jacobson 2015).

The Medicaid expansion protected individuals from a broad range of negative financial shocks. High levels of out-of-pocket spending, which are sometimes called “catastrophic” or “high-burden,” declined due to the Medicaid expansion (Blavin et al. 2018; Glied, Chakraborty, and Russo 2017; Goldman et al. 2018; Zewde and Wimer 2019). Reductions in catastrophic spending, combined with the fact that money not spent on medical bills can be reallocated to other family needs, presage the wider-reaching financial effects produced by expanded access to health insurance. Medicaid expansion produced declines in medical debt, especially in the poorest communities (Brevoort, Grodzicki, and Hackmann 2017). The program reduces both medical and non-medical bills in collections (Caswell and Waidmann 2017). Medicaid reduces the debt past-due, and decreases the likelihood of new financial delinquencies (Brevoort, Grodzicki, and Hackmann 2017; Hu et al. 2018). This affirms similar past findings from the Massachusetts health reform, a sweeping policy change that included health insurance expansion to adults (Mazumder and Miller 2016). There is evidence of a link between insurance access and the ability to afford housing. Recent studies find that California's Low Income Health Program reduced evictions, and that the ACA tax subsidies for marketplace health insurance reduced mortgage delinquencies (Gallagher, Gopalan, and Grinstein-Weiss 2019; Allen et al. 2019).

Reductions in individual debts and delinquencies expand future financial prospects. Poverty levels declined in ACA expansion states (Zewde and Wimer 2019). Credit scores improved as a result of Medicaid expansion (Brevoort, Grodzicki, and Hackmann 2017; Caswell and Waidmann 2017). These findings are consistent with past work on the Massachusetts health reform (Mazumder and Miller 2016). Improved credit scores among low-income individuals lead to more credit offers on better financial terms. These offers include auto loans and mortgages, again signaling the far reach of Medicaid expansion on financial health (Brevoort, Grodzicki, and Hackmann 2017). In addition to improvements for the average affected person, there were also reductions in worst-case financial scenarios; specifically, bankruptcy filings decreased as a result of Medicaid expansion (Brevoort, Grodzicki, and Hackmann 2017; Caswell and Waidmann 2017).

Behavioral Health Summary

Mental Health

The strongest evidence for Medicaid’s effects on mental health care comes from the Oregon Health Insurance Experiment. The Oregon study found that Medicaid expansion led to improved reports of mental health status and also increased the number of diagnoses of depression and prescriptions for mental health drugs, of which the majority were anti-depressants (Finkelstein et al. 2012; Baicker et al. 2017; Baicker et al. 2018). The program reduced the share of individuals with untreated depression, and virtually eliminated untreated depression among those who had had a positive screening for the condition before the Medicaid study began (Baicker et al. 2018). Although access to mental health treatment was greatly improved as the result of the opportunity to apply for Medicaid in the Oregon experiment, the improvements appeared to be linked to the mental relief and financial reprieve associated with having health insurance, not necessarily to mental health treatment (Finkelstein et al. 2012; Baicker et al. 2018).

Findings on the use of mental health services from ACA expansion studies are more mixed. A study of depressed adults in three Medicaid expansion states found no post-expansion change in care utilization and no reported difficulty of making specialist appointments (Fry and Sommers 2018). Similarly, another study found no increase in the use of mental health services, even among a population with moderate-to-severe psychological distress (Golberstein and Gonzales 2015). In that case, small sample sizes may have limited the authors’ ability to detect changes. In contrast to these null findings, one larger study of the ACA found that a population with severe psychological distress or a history of substance use disorder was more likely to receive treatment in the ACA era (Creedon and Cook 2016).

Despite the mixed findings on utilization, improvements in mental health status were consistently found across national studies, and aligned with the Oregon findings. Medicaid expansion improved self-reported measures of mental health, including a reduction in the number of poor mental health days (Winkelman and Chang 2018). An earlier Medicaid expansion led to declines in psychological distress and reductions in unmet need for mental health care due to cost among low-income parents (McMorrow et al. 2016). The ACA Medicaid expansion reduced psychological distress, but this was likely due to improved financial security, since the use of mental health services did not increase (McMorrow et al. 2017).

In the area of behavioral health, there is strong evidence that Medicaid expansion improved mental health outcomes, increased access to treatment for opioid use disorder, and may have increased access to mental health services. These improvements to mental health may result as much from mental health care as from improved financial stability and reduced psychological distress caused by not having health insurance.²

Substance Use Disorder

The findings on the effects of Medicaid expansion on substance abuse treatment are mixed, reflecting the fact that a lack of insurance is only one barrier to seeking treatment and improving outcomes among adults with substance use disorder. Expansion-related findings for substance use and its treatment are set against the backdrop of an overall decline in prescriptions for opioid pain medications, which occurred across all payers around the period of the policy rollout (Saloner et al. 2018). Medicaid expansion did not reduce opioid prescription beyond the national decline (Cher, Morden, and Meara 2019). Research to date finds no evidence that Medicaid expansion increased utilization of the general category of treatment for substance use disorder (Maclean and Saloner 2019;

² Sometimes this is called the “warm glow” effect of health insurance.

Olfson et al. 2018). This may be partially attributable to the fact that the supply and capacity of treatment facilities have not increased in expansion states (Andrews et al. 2019).

Positive findings for access to treatment are concentrated in the treatment of specific substances. Medicaid expansion increased admissions to specialty treatment for opioid use (Meinhofer and Witman 2018; Maclean and Saloner 2019). The expansion also increased the number of physicians with prescribing authority for buprenorphine, a medication used in the treatment of opioid use disorder (Knudsen et al. 2015). Buprenorphine prescriptions themselves increased as a result of the Medicaid expansion (Wen et al. 2017; Saloner et al. 2018). In addition, Medicaid expansion was associated with increased treatment for alcohol use disorder in Oregon (McCarty et al. 2018).

The expansion led to Medicaid taking on a larger role as a payer for the treatment of opioid use. Among Medicaid beneficiaries, buprenorphine prescriptions increased relative to other classes of drugs that are highly prescribed for this population (Cher, Morden, and Meara 2019). Medicaid coverage for those in inpatient opioid treatment increased (Meinhofer and Witman 2018; Maclean and Saloner 2019). Medicaid-paid outpatient medication-assisted treatment also increased (Andrews et al. 2019). However, increases in buprenorphine prescriptions occurred for all payers, not just Medicaid (Saloner et al. 2018). These combined results suggest that Medicaid may have increased access to medication-assisted treatment for the previously uninsured.

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