

Jeopardizing a Sound Investment: Why Short-Term Cuts to Medicaid Coverage During Pregnancy and Childhood Could Result in Long-Term Harm

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ABSTRACT

ISSUE: States are facing large revenue shortfalls and budget deficits from the COVID-19 crisis. To close deficits, they will need to raise taxes, cut spending to critical public programs like Medicaid, or both.

GOALS: Examine the long-term benefits of Medicaid coverage of children and pregnant women, and the likely impact of state Medicaid cuts for the short and long term.

METHODS: Review of research literature on the long-term benefits of Medicaid coverage of children and pregnant women.

KEY FINDINGS: Research shows Medicaid coverage of children and pregnant women is associated with improved health and lower rates of disability in adulthood. Medicaid coverage is also associated with higher educational attainment and greater financial security. Some studies find that Black children particularly benefit. Medicaid also produces financial benefits for society and a strong return on government investment.

CONCLUSIONS: Because state and federal policymakers tend to focus more on short-term budget windows, they do not always consider long-term consequences. In addition to further temporary boosts in federal Medicaid funding, one potential policy solution is an automatic federal funding increase to avert Medicaid budget cuts during future economic downturns.

TOPLINES

- ▶ Medicaid coverage of children and their pregnant mothers helps improve children's health outcomes well into adulthood.
- ▶ Research shows government funding of Medicaid has a strong return on investment.



INTRODUCTION

Medicaid covers nearly 39 percent of children nationwide.¹ A growing and robust body of research finds that Medicaid coverage of children, and of their mothers during pregnancy, is associated with many long-term benefits in adulthood. These include better health, reduced disability, greater educational attainment, and better financial outcomes, with some studies finding particular benefits for Black children. Although the immediate benefits of Medicaid coverage — including increased access to care for children and greater financial security for families — are well accepted, the long-term benefits are not as widely known.²

As nearly all states are required to balance their budgets, state policymakers will likely consider cutting their Medicaid programs to address the large revenue shortfalls and budget deficits resulting from the COVID-19 public health and economic crisis. Such financial challenges could extend beyond this year for several years to come. Because Medicaid is a federal–state financial partnership, the federal government picks up a fixed share of states’ Medicaid costs. This means that when states cut Medicaid to reduce their spending, they lose federal matching funds as well, creating a “multiplier” effect resulting in larger total Medicaid cuts that could deepen and prolong the recession. Medicaid is the largest source of federal funding in state budgets, so this effect is substantial.

Medicaid cuts affecting children and pregnant women also could produce long-term harm by leading to poorer health and economic outcomes for low-income children later in life. It is well documented that both higher income and greater educational attainment are linked to better health, including reduced mortality and incidence of disease.³ Along with systemic racism, lower incomes and

less educational attainment are key contributors to the significant health disparities experienced by communities of color. Although the majority of children enrolled in Medicaid are white, Black, Latino, and American Indian/Alaska Native children disproportionately receive health coverage through Medicaid.⁴ As a result, Medicaid cuts could particularly harm communities of color, in both the short and long term.

KEY FINDINGS

Studies of Medicaid coverage of children and pregnant women generally use a similar methodology: they examine differences in outcomes for distinct age cohorts born before and after Medicaid expansions for children and pregnant women were implemented. For example, mandatory increases in Medicaid minimum income eligibility levels for children and pregnant women were phased in during the 1980s and 1990s, and more expansions occurred in the late 1990s and early 2000s after the Children’s Health Insurance Program (CHIP) was implemented.

Because states took up these expansions at different times and to a different extent, researchers are able to examine how children’s outcomes were affected by this variation. The following are some of the key findings.

Medicaid and Better Health in Adulthood

Medicaid coverage of children and pregnant women is linked to fewer chronic conditions, better overall health, improved oral health, and fewer hospitalizations and emergency room visits in adulthood. Most importantly, Medicaid is associated with lower mortality and longer lives. It also may produce better outcomes in the next generation of children.

Medicaid’s Long-Term Impact on Health



Better overall
health and
reduced mortality



Improved
oral health



Fewer chronic
conditions



Fewer
hospitalizations



Fewer
ER visits

Better health. Medicaid coverage in early life is associated with a decreased incidence of chronic conditions as measured by an index of conditions (obesity, diabetes, heart disease or heart attack, and high blood pressure) in adults ages 19–36.⁵ Eligibility for Medicaid for low-income children also is linked to improved health in adulthood (ages 25–54), as measured by a composite health index (high blood pressure, diabetes, heart disease/heart attack, and obesity).⁶

An additional year of Medicaid eligibility in childhood was associated with improvement in an index of conditions (ability to attend school, self-reported health status, chronic conditions, and asthma) among young adults ages 18–20.⁷ Medicaid coverage of pregnant women and infants in the first year of life was linked to better oral health (as measured by loss of permanent teeth) in non-Hispanic Black adults ages 19–31.⁸

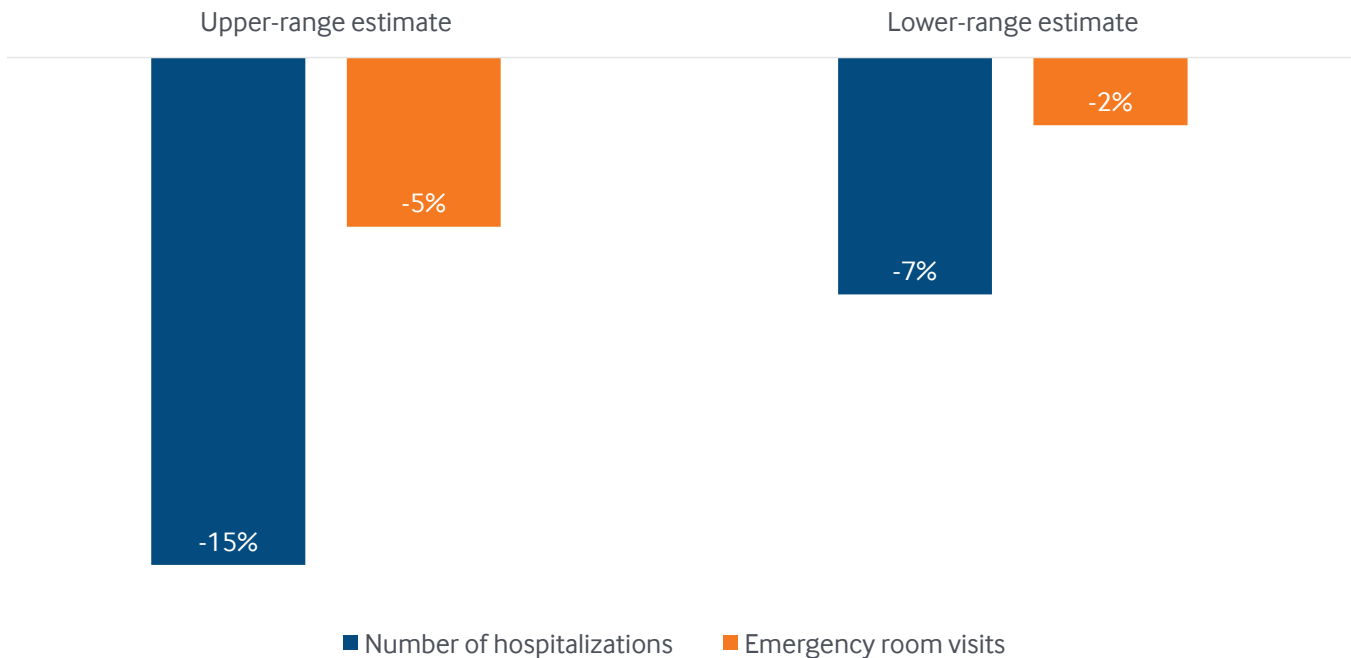
Fewer hospitalizations and emergency room visits.

Medicaid in early childhood is associated with a reduction

in hospitalizations, particularly related to diabetes and obesity, in adults ages 19–36.⁹ More years of childhood eligibility for Black children also is linked to decreased hospitalizations at age 25. More years of Medicaid coverage also were associated with fewer emergency room visits, particularly visits related to chronic illnesses and visits for those living in low-income zip codes (Exhibit 1).¹⁰

Lower mortality rates. Each additional year of Medicaid childhood eligibility is associated with a decline in mortality rates among young adults.¹¹ A year of childhood eligibility also was linked to reduced cumulative mortality (unrelated to HIV/AIDS) in adulthood.¹² Years of Medicaid eligibility in childhood lowered mortality rates (from internal causes such as cancer, nervous system diseases, and infectious diseases) among Black adolescents and young adults (ages 15–23).¹³ Age cohorts born after Medicaid was established had lower mortality rates throughout childhood and into adulthood, with the strongest association in the oldest age group studied (ages 36–40).¹⁴

Exhibit 1. Effect of Medicaid Child Expansions on Health Care Utilization by Black Young Adults at Age 25



Data: Laura R. Wherry et al., “Childhood Medicaid Coverage and Later-Life Health Care Utilization,” *Review of Economics and Statistics* 100, no. 2 (May 2018): 287–302.

Healthier birth weight in next generation of children.

Medicaid coverage of pregnant women was associated with higher, healthier birth weight for their children. In combination with childhood Medicaid eligibility, Medicaid also was associated with higher, healthier birth weight for the following generation of children as well.¹⁵

Medicaid and Lower Incidence of Disability in Adulthood

Children who were eligible for Medicaid were less likely to report having disabilities and to apply for disability benefits as adults.

- **Less self-reported disability.** Adults under age 65 reported fewer challenges with activities of daily living, including ambulatory difficulty, if they were likely eligible for Medicaid in early childhood.¹⁶
- **Reduced need for disability benefits.** Early childhood Medicaid coverage (under age 12) was associated with

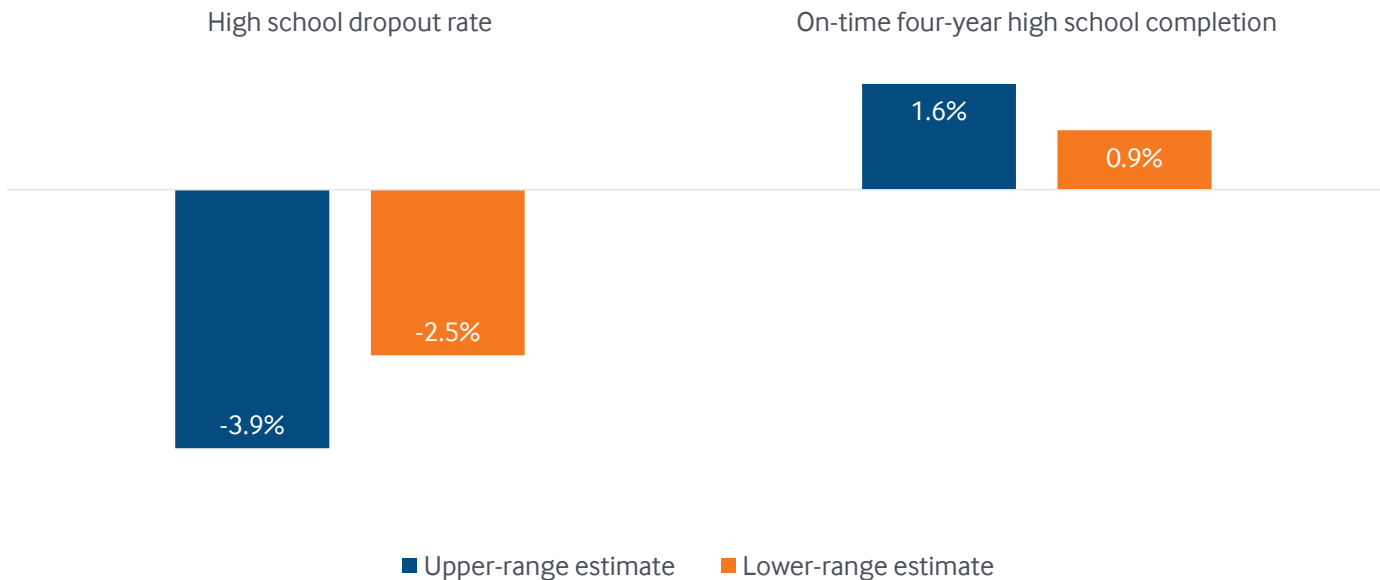
lower application rates for Social Security Disability Insurance (SSDI) among adults ages 25–64.¹⁷ Medicaid eligibility throughout childhood also reduced Supplemental Security Income (SSI) applications among young adults (ages 20–28).¹⁸

Medicaid and Higher Educational Attainment

Medicaid coverage of children, and of their mothers during pregnancy, was associated with increased rates of high school graduation, on-time high school graduation, college enrollment, and four-year college graduation.

Higher high school graduation rates. Medicaid eligibility for pregnant women and children was associated with a greater likelihood of children graduating from high school.¹⁹ Children’s eligibility for Medicaid and CHIP was linked to a decrease in the high school dropout rate, particularly among children of color.²⁰ It also increased the probability of completing high school on time in four years, especially for Latino and white children (Exhibit 2).²¹

Exhibit 2. Effect of 10-Percentage-Point Increase in Childhood Medicaid Eligibility on High School Graduation



Data: Lincoln H. Groves, “Still ‘Saving Babies’? The Impact of Child Medicaid Expansions on High School Completion Rates,” *Contemporary Economic Policy* 38, no. 1 (Jan. 2020): 109–26.

Higher college enrollment and graduation rates. Medicaid eligibility in childhood was associated with an increase in college enrollment rates among young adults, with larger effects for children with more years of Medicaid eligibility.²² It also increased the likelihood of obtaining a four-year college degree, especially among white children.²³

Medicaid and Greater Financial Security in Adulthood

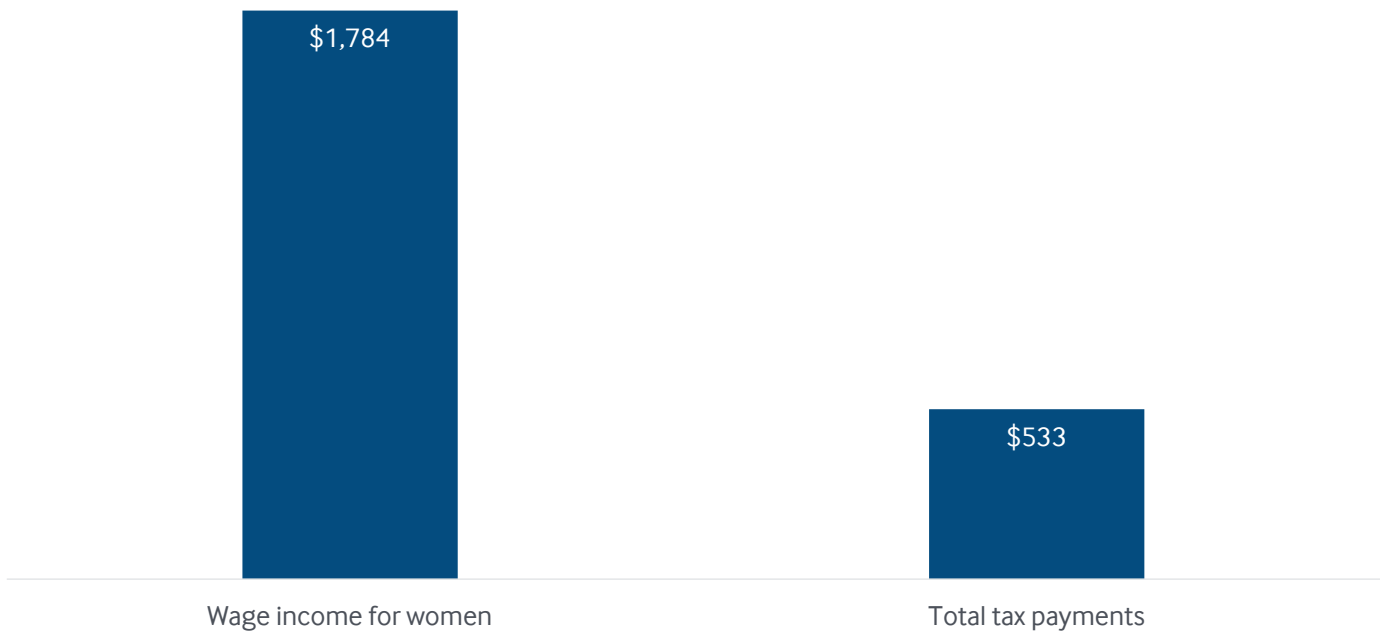
Medicaid coverage of children and pregnant women produces considerable financial benefits for both individuals and society at large. It raises both children’s earnings in adulthood and improves intergenerational mobility, which, in turn, increase tax payments that help offset the earlier investment in health coverage.

Higher earnings and higher total tax payments. Women with more years of childhood Medicaid eligibility had higher wage income as young adults, especially for those who remained eligible through the teenage years (Exhibit 3).²⁴ Each additional year of childhood Medicaid eligibility was associated with an increase in total federal tax payments made in adulthood. Higher income taxes and payroll taxes paid (because of higher earnings) constituted the large majority of the increase, with reduced reliance on the Earned Income Tax Credit (EITC) also a factor. The share of these higher total tax payments (because of higher income taxes on higher earnings) grew with age.²⁵

Medicaid’s Long-Term Impact on Educational Attainment

High school graduation	On-time high school graduation
College enrollment	Four-year college graduation

Exhibit 3. Increased Income and Total Tax Payments for Each Additional Year of Childhood Medicaid Eligibility by Age 28



Data: David W. Brown, Amanda E. Kowalski, and Ithai Z. Lurie, “Long-Term Impacts of Childhood Medicaid Expansions on Outcomes in Adulthood,” *Review of Economic Studies* 87, no. 2 (Mar. 2020): 792–821.

Greater intergenerational mobility. Medicaid coverage during pregnancy and in the first year of life was linked to increased economic mobility, as measured by a reduction in the correlation between income percentile rankings of low-income parents and their children in adulthood. Specifically, increased Medicaid eligibility for those with incomes in the 10th percentile was associated with a greater likelihood of being in a higher income percentile later in life.²⁶

Strong rate of return on government investment. More than half of the cost of Medicaid coverage in childhood was offset by higher tax receipts in adulthood.²⁷ The cost of coverage also was partially offset by reductions in disability benefit payments.²⁸ Lower total costs related to reduced hospitalizations in adulthood also may offset a portion of the cost of Medicaid coverage.²⁹ Medicaid coverage of children and pregnant women also had a high marginal value of public funds — a measure of how much in “welfare” can be delivered to beneficiaries for every dollar of net government spending.³⁰ In fact, the same study found that Medicaid coverage may have fully paid for itself by the time eligible children reached age 36.³¹

POLICY IMPLICATIONS

States are facing \$300 billion to \$400 billion in estimated total budget deficits through FY2022, largely because of revenue shortfalls resulting from the pandemic.³² To close these deficits, as is required by state law in nearly all states, states will have to raise revenues through higher taxes, cut spending, or both.³³

Medicaid is at significant risk of damaging budget cuts, especially for provider reimbursement cuts that could reduce access to needed care (see box). That is because it accounted for 19.7 percent of state general fund spending in 2019, second only to K–12 education and higher education, which together accounted for 45.2 percent of state spending.³⁴ As a consequence, children are at considerable risk that state budget cuts could adversely affect both their access to health care and their education in the short and longer term.³⁵

“FAMILIES FIRST” RESTRICTIONS ON MEDICAID CUTS

The Families First COVID-19 legislation (P.L. 116–127) includes a maintenance-of-effort requirement that prohibits states from cutting Medicaid eligibility and benefits, imposing stricter eligibility procedures, or disenrolling beneficiaries involuntarily for the duration of the public health emergency as a condition of a temporary 6.2 percent increase in the federal Medicaid matching rate (also known as the Federal Medical Assistance Percentage, or FMAP). Under separate federal law (P.L. 115–120 and P.L. 115–123), states are prohibited from cutting eligibility for children in families with incomes below 300 percent of the federal poverty level or imposing more restrictive eligibility procedures under both Medicaid or CHIP through September 30, 2027.

States, however, may still cut Medicaid in other ways during the public health emergency. For example, they could reduce Medicaid reimbursement rates to hospitals, physicians, dentists, nursing homes, and other providers. Such cuts could increase stress on providers coping with additional costs, sharply reduced revenues from declines in service utilization, and limited (or delayed) federal assistance during the COVID-19 crisis. Reimbursement rate cuts also could reduce access to needed care if providers scale back the services they furnish to Medicaid beneficiaries, limit the number of Medicaid patients they see, no longer participate in Medicaid, or cease operations altogether.

Sources: Manatt Health, “*Targeted Options for Increasing Medicaid Payments to Providers During COVID-19 Crisis*,” State Health and Value Strategies, Apr. 2020; MaryBeth Musumeci et al., “*Options to Support Medicaid Providers in Response to COVID-19*” (Henry J. Kaiser Family Foundation, June 2020); National Association of Medicaid Directors, “*NAMD Joins Medicaid Provider and Plan Groups to Request Support for Critical Medicaid Providers*,” Letter, NAMD, May 8, 2020; and Sarah Klein and Martha Hostetter, “*Safety-Net Providers Focus on Population Health and Community Outreach as Part of Their Pandemic Response*” (Commonwealth Fund, Nov. 2020).

Medicaid is the largest source of federal funding for states, constituting 58.2 percent of all federal funding in state budgets in 2019.³⁶ Because the federal government picks up a fixed share of states' Medicaid costs, cuts to the program have a significant multiplier effect. With the Families First FMAP increase of 6.2 percentage points, every \$1 in reduced state spending will result in an additional loss of federal Medicaid funding, ranging from \$1.28 in Colorado to \$5.23 in Mississippi in fiscal year 2021.

As a result, when a state cuts \$1 in its own funding from its Medicaid program, the actual federal and state Medicaid spending cut is considerably larger — \$2.28 to \$6.23, depending on the state — and its impact also will be greater (see [Appendix](#)).³⁷ Without additional fiscal relief, the adverse effects of these Medicaid cuts on a state's economy could deepen and prolong the COVID-19-related recession, weaken its health care system, and lead to bigger state budget deficits for a longer period.³⁸

These cuts would likely reduce access to needed care for the tens of millions of children and parents, pregnant women, people with disabilities, seniors, and other adults enrolled in Medicaid. As this review of the research indicates, cuts to Medicaid may be particularly shortsighted. They not only could harm children's access to needed care in the short term and further exacerbate COVID-19-related state budget deficits, but they also could harm children's long-term outcomes in the areas of health, disability, education, and financial security.

One policy option for addressing state budget shortfalls and averting harmful Medicaid cuts is to not only provide a further temporary increase in federal Medicaid funding but also to add a permanent feature to the Medicaid program under which federal Medicaid funding would automatically increase during future economic downturns.³⁹ That would strengthen state Medicaid programs over the long run by ensuring they could avoid harmful cuts and meet the needs of both new and existing beneficiaries. Such a feature also could help Medicaid increase spending to offset reduced economic activity and thus shore up state economies during downturns.⁴⁰ This approach also could lead to better life outcomes for low-income children in adulthood. This is especially critical to communities of color, whose children

disproportionately rely on Medicaid for their health coverage.

Given the long-term benefits of investments in Medicaid coverage, policy options during the postpandemic recovery include further improving Medicaid and CHIP coverage for children and families and expanding access to needed care. At the federal level, this could involve automatic Medicaid enrollment of newborns, elimination of eligibility restrictions based on citizenship status, increases in minimum Medicaid and CHIP eligibility levels for children, and expanded continuous eligibility.⁴¹ It also could include one year of postpartum coverage for low-income women to ensure the health of new mothers and their babies.⁴²

Such reforms would likely result in further enhancements of children's long-term outcomes. They also would help improve health outcomes and reduce racial disparities in many areas, such as maternal and infant health, once health coverage is more assured.

CONCLUSION

A growing body of research finds that Medicaid coverage of children, and of their mothers during pregnancy, is associated with improved health, reduced disability, greater educational attainment, and better financial outcomes when they grow up to be adults. Any cuts to Medicaid to address revenue shortfalls and budget deficits resulting from the COVID-19 crisis could have a significant long-term adverse impact.

Providing additional federal Medicaid funding now, as well as permanent, automatic increases in federal support, could help ensure access to health coverage and care in future economic downturns. Further improvements to Medicaid and CHIP could enhance outcomes for children in adulthood.

HOW WE CONDUCTED THIS STUDY

We conducted a comprehensive review of the research literature related to the long-term benefits of Medicaid coverage of pregnant women and children when children reach adulthood. It builds on a prior review of the research literature conducted by the Georgetown University Center for Children and Families in 2017.⁴⁵

NOTES

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3. Steven Woolf et al., *How Are Income and Wealth Linked to Health and Longevity* (Urban Institute and Center on Society and Health, Apr. 2015); and Center on Society and Health, *Education: It Matters More to Health Than Ever Before* (Center on Society and Health, Feb. 2015).
4. Tricia Brooks and Allexa Gardner, *Snapshot of Children with Medicaid by Race and Ethnicity, 2018* (Georgetown University Center for Children and Families, July 2020).
5. Sarah Miller and Laura R. Wherry, “The Long-Term Effects of Early Life Medicaid Coverage,” *Journal of Human Resources* 54, no. 3 (Summer 2019): 785–824.
6. Michel H. Boudreaux, Ezra Golberstein, and Donna D. McAlpine, “The Long-Term Impacts of Medicaid Exposure in Early Childhood: Evidence from the Program’s Origin,” *Journal of Health Economics* 45 (Jan. 2016): 161–75.
7. Owen Thompson, “The Long-Term Health Impacts of Medicaid and CHIP,” *Journal of Health Economics* 51 (Jan. 2017): 26–40.
8. Brandy J. Lipton et al., “Lasting Positive Effects on Oral Health of Non-Hispanic Black Children,” *Health Affairs* 35, no. 12 (Dec. 2016): 2249–58.
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10. Laura R. Wherry et al., “Childhood Medicaid Coverage and Later-Life Health Care Utilization,” *Review of Economics and Statistics* 100, no. 2 (May 2018): 287–302.
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12. Andrew Goodman-Bacon, *The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes*, NBER Working Paper no. 22899 (National Bureau of Economic Research, Dec. 2016).
13. Laura R. Wherry and Bruce D. Meyer, “Saving Teens: Using a Policy Discontinuity to Estimate the Effects of Medicaid Eligibility,” *Journal of Human Resources* 51, no. 3 (Summer 2016): 556–88.
14. Heeju Sohn, “Medicaid’s Lasting Impressions: Population Health and Insurance at Birth,” *Social Science & Medicine* 177 (Mar. 2017): 205–12.
15. Chloe N. East et al., *Multi-Generational Impacts of Childhood Access to the Safety Net: Early Life Exposures to Medicaid and the Next Generation’s Health*, NBER Working Paper no. 23810 (National Bureau of Economic Research, Feb. 2019).
16. Tanya Byker and Andrew Goodman-Bacon, *The Long-Run Effects of Medicaid on Disability Applications* (National Bureau of Economic Research, Aug. 2018); and Goodman-Bacon, *Long-Run Effects Childhood*, 2016.
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19. Miller and Wherry, “Long-Term Effects,” 2019.
20. Sarah R. Cohodes et al., “[The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions](#),” *Journal of Human Resources* 51, no. 3 (Summer 2016): 727–59; and Lincoln H. Groves, “[Still ‘Saving Babies’? The Impact of Child Medicaid Expansions on High School Completion Rates](#),” *Contemporary Economic Policy* 38, no. 1 (Jan. 2020): 109–26.
21. Groves, “Still ‘Saving Babies’?,” 2020.
22. Brown, Kowalski, and Lurie, “Long-Term Impacts,” 2020.
23. Cohodes et al., “Effect of Child Health Insurance,” 2016.
24. By age 28, each additional year of Medicaid eligibility resulted in \$1,784 higher cumulative wage income, compared with a base cumulative wage income of \$136,600. See Brown, Kowalski, and Lurie, “Long-Term Impacts,” 2020.
25. By age 28, each additional year of Medicaid eligibility resulted in \$533 more in total taxes, compared with a base of \$20,623. See Brown, Kowalski, and Lurie, “Long-Term Impacts,” 2020.
26. Rourke L. O’Brien and Cassandra L. Robertson, “[Early-Life Medicaid Coverage and Intergenerational Economic Mobility](#),” *Journal of Health and Social Behavior* 59, no. 2 (June 2018): 300–15.
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33. Tax Policy Center, “Chapter 5: The State of State (and Local) Tax Policy,” in *Briefing Book* (TPC, June 2020); Kim Rueben and Megan Randall, *Balanced Budget Requirements: How States Limit Deficit Spending* (Urban Institute, Nov. 2017); and National Conference of State Legislatures, *NCSL Fiscal Brief: State Balanced Budget Provisions* (NCSL, Oct. 2010).
34. In 2019, K–12 education constituted 35.6 percent of state general fund spending, and higher education constituted 9.6 percent of state general fund spending. See National Association of State Budget Officers, *State Expenditure Report: 2019 State Expenditure Report, Fiscal Years 2017–2019* (NASBO, Nov. 2019).
35. To generate support at the federal and state levels for proposals to cut federal Medicaid funding through block grants and per capita caps, critics of Medicaid often claim that Medicaid is “crowding out” state K–12 education spending. Instead, such proposals would likely impose considerable fiscal pressures on overall state budgets. And because K–12 education accounts for the largest share of state general fund spending, it would likely be at risk for significant cuts. See Edwin Park, *Illustrating the Harmful Impact of Medicaid Block Grants and Per Capita Caps on State Funding of K–12 Education* (Georgetown University Center for Children and Families, July 9, 2020).
36. NASBO, *2019 State Expenditure Report*, 2019.
37. This is for Medicaid spending subject to the regular FMAP. For the Medicaid expansion (which has a 90% matching rate), for every \$1 in state Medicaid cuts, federal funding would be cut by \$9, equaling an actual total federal and state cut of \$10. For most administrative costs (which have a 50% matching rate), for every \$1 in state Medicaid cuts, federal funding would be cut by \$1, equaling an actual total federal and state cut of \$2.

38. Edwin Park, “[State Budget Cuts to Medicaid Means Reduced Federal Funding, Larger Total Cuts](#),” *Say Ahhh! Blog*, Georgetown University Center for Children and Families, May 7, 2020.
39. Matthew Fiedler, Jason Furman, and William Powell III, [Increasing Federal Support for Medicaid and CHIP Programs in Response to Economic Downturns](#) (Brookings Institution, May 2019).
40. Cindy Mann and Elizabeth Dervan, “[Ensuring People Have the Medicaid Coverage They Need During the Economic Crisis](#),” *To the Point* (blog), Commonwealth Fund, May 6, 2020.
41. Kelly Whitener and Joan Alker, [Covering All Children](#) (Georgetown University Center for Children and Families, Feb. 2020).
42. Stacy McMorrow et al., [Uninsured New Mothers’ Health and Health Care Challenges Highlights the Benefits of Increasing Postpartum Medicaid Coverage](#) (Urban Institute, May 2020).
43. Karina Wagnerman, Alisa Chester, and Joan Alker, [Medicaid Is a Smart Investment in Children](#) (Georgetown University Center for Children and Families, Mar. 2017).

Appendix. Impact of State Medicaid Budget Cuts on Federal Medicaid Matching Funds, Fiscal Year 2021

State/Territory	Regular FMAP	Families First FMAP*	Reduction in federal funding for every \$1 cut in state funding	Total Medicaid spending cut for every \$1 cut in state funding
Alabama	72.58%	78.78%	\$3.71	\$4.71
Alaska	50.00%	56.20%	\$1.28	\$2.28
Arizona	70.01%	76.21%	\$3.20	\$4.20
Arkansas	71.23%	77.43%	\$3.43	\$4.43
California	50.00%	56.20%	\$1.28	\$2.28
Colorado	50.00%	56.20%	\$1.28	\$2.28
Connecticut	50.00%	56.20%	\$1.28	\$2.28
Delaware	57.74%	63.94%	\$1.77	\$2.77
District of Columbia	70.00%	76.20%	\$3.20	\$4.20
Florida	61.96%	68.16%	\$2.14	\$3.14
Georgia	67.03%	73.23%	\$2.74	\$3.74
Hawaii	53.02%	59.22%	\$1.45	\$2.45
Idaho	70.41%	76.61%	\$3.28	\$4.28
Illinois	50.96%	57.16%	\$1.33	\$2.33
Indiana	65.83%	72.03%	\$2.58	\$3.58
Iowa	61.75%	67.95%	\$2.12	\$3.12
Kansas	59.68%	65.88%	\$1.93	\$2.93
Kentucky	72.05%	78.25%	\$3.60	\$4.60
Louisiana	67.42%	73.62%	\$2.79	\$3.79
Maine	63.69%	69.89%	\$2.32	\$3.32
Maryland	50.00%	56.20%	\$1.28	\$2.28
Massachusetts	50.00%	56.20%	\$1.28	\$2.28
Michigan	64.08%	70.28%	\$2.36	\$3.36
Minnesota	50.00%	56.20%	\$1.28	\$2.28
Mississippi	77.76%	83.96%	\$5.23	\$6.23
Missouri	64.96%	71.16%	\$2.47	\$3.47
Montana	65.60%	71.80%	\$2.55	\$3.55
Nebraska	56.47%	62.67%	\$1.68	\$2.68
Nevada	63.30%	69.50%	\$2.28	\$3.28
New Hampshire	50.00%	56.20%	\$1.28	\$2.28
New Jersey	50.00%	56.20%	\$1.28	\$2.28
New Mexico	73.46%	79.66%	\$3.92	\$4.92
New York	50.00%	56.20%	\$1.28	\$2.28
North Carolina	67.40%	73.60%	\$2.79	\$3.79
North Dakota	52.40%	58.60%	\$1.42	\$2.42
Ohio	63.63%	69.83%	\$2.31	\$3.31
Oklahoma	67.99%	74.19%	\$2.87	\$3.87
Oregon	60.84%	67.04%	\$2.03	\$3.03
Pennsylvania	52.20%	58.40%	\$1.40	\$2.40
Rhode Island	54.09%	60.29%	\$1.52	\$2.52
South Carolina	70.63%	76.83%	\$3.32	\$4.32
South Dakota	58.28%	64.48%	\$1.82	\$2.82
Tennessee	66.10%	72.30%	\$2.61	\$3.61
Texas	61.81%	68.01%	\$2.13	\$3.13
Utah	67.52%	73.72%	\$2.81	\$3.81
Vermont	54.57%	60.77%	\$1.55	\$2.55
Virginia	50.00%	56.20%	\$1.28	\$2.28
Washington	50.00%	56.20%	\$1.28	\$2.28
West Virginia	74.99%	81.19%	\$4.32	\$5.32
Wisconsin	59.37%	65.57%	\$1.90	\$2.90
Wyoming	50.00%	56.20%	\$1.28	\$2.28
American Samoa	83.00%	89.20%	\$8.26	\$9.26
Guam	83.00%	89.20%	\$8.26	\$9.26
Northern Mariana Islands	83.00%	89.20%	\$8.26	\$9.26
Puerto Rico	76.00%	82.20%	\$4.62	\$5.62
U.S. Virgin Islands	83.00%	89.20%	\$8.26	\$9.26

Note: FMAP = Federal Medical Assistance Percentage.

* Families First (P.L. 116-127) FMAP increase in effect starting January 1, 2020, and for any subsequent calendar year quarter during which COVID-19 public health emergency declaration remains in effect. Some Medicaid spending is subject to a different matching rate (e.g., 90% for the Medicaid expansion and 50% for most administrative costs); as a result, the “multiplier” effect also will be different.

Data: Georgetown University Center for Children and Families (CCF) analysis.

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