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Medicaid Expansion Promotes Children's Development and Family Success by Treating Maternal Depression

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Key Findings

1. Untreated maternal depression is a major public health problem that affects large numbers of women, especially low-income women, and their children. More than half (55 percent) of poor infants have a mother who is experiencing some level of depressive symptoms. Maternal depression has been shown to undercut children's healthy development and stymie women's efforts to escape poverty.
2. While safe and effective treatments exist, low-income and uninsured women are far less likely to get treatment; more than one-third (37 percent) of low-income mothers with young children who have had a major depressive disorder do not receive any treatment. Lack of health insurance or other means to pay for care creates a challenging barrier.
3. In states that have not expanded Medicaid, many poor mothers lack health insurance. In the 19 states that have refused federal funds to expand Medicaid coverage, 500,000 mothers fall into a coverage gap, ineligible for Medicaid and unable to afford private insurance.
4. Expanding Medicaid coverage to low-income adults (including mothers) offers states a major opportunity to increase screening, identification, and treatment of maternal depression—thereby promoting young children's healthy development and family economic security. Access to Medicaid reduces the incidence of depression by increasing access to mental health services and diminishing financial barriers to care. Identifying and treating maternal depression also has the potential to save money for state Medicaid programs by improving other health issues faced by children and mothers.

Introduction

This paper examines one important reason why access to Medicaid for poor adults is crucial for *children's* healthy development. Other research has documented the reasons why Medicaid coverage matters so much for uninsured *adults*, both parents and non-parents: It reduces the rate of uninsurance, allows them to get treatment for medical and mental health problems, and stabilizes family finances.[1] But it can be less obvious why adults' coverage should matter for children, who were not targeted by the Medicaid eligibility expansions in the Affordable Care Act (ACA).

Yet adults' coverage matters crucially for children, because children's development depends on whether the caring adults in their lives—particularly their parents—are themselves healthy emotionally and physically. This paper addresses one particularly well-studied example of this close relationship between parents' health and children's development: maternal depression. Specifically, it summarizes the evidence that a mother's untreated depression can hinder children's healthy development; that safe and effective treatments exist, yet low-income mothers too often don't get treatment; and that Medicaid coverage could change that.

Policymakers, community leaders, practitioners, advocates, and others with a deep commitment to children's—and especially young children's—healthy development and educational success should see Medicaid expansion as a core priority. Without healthy parents capable of being the best possible caregivers, children face unnecessary obstacles to their own development.

Untreated Maternal Depression Hinders Low-Income Children's Development

More than half (55 percent) of poor infants (under one year old) have a mother who is experiencing some level of depressive symptoms and 11 percent have a mother experiencing severe depression.

Maternal depression is a major public health problem that interferes with a parent's capacity to help a child develop and that stymies efforts to escape poverty. Even though research shows that effective treatments for depression address these challenges, low-income mothers of young children have very high rates of untreated depression—for reasons that include being uninsured and not having other means to pay for care.[2]

The enactment of the ACA created a set of new policy opportunities for states to address maternal depression in low-income populations. Key changes include minimum standards for mental health benefits; provisions that support attention to depression, such as through quality indicators and free preventive coverage of screening; and a focus on integrated care, quality improvement, and reducing fragmentation between primary care and mental health providers.[3] The ACA has also provided states with the ability to cover more low-income adults by expanding Medicaid coverage to adults with income up to 138 percent of the Federal Poverty Level (FPL). To date, 32 states (including the District of Columbia) have expanded Medicaid and 19 states have not.[4] (See Figure 1 on page 5.)

High Prevalence of Maternal Depression

Maternal depression is widespread among women in the United States, particularly poor women and women with young children (under six years of age). Among mothers with young children, 15 percent (2.6 million) have had major depression at some time in their lives and 8 percent experienced major depression in the last year. Low-income mothers (with income under 200 percent of the FPL) have higher rates of major depression in the last year (9 percent) than all women (8 percent).[5] More than half (55 percent) of poor infants (under one year old) have a mother who is experiencing some level of depressive symptoms and 11 percent have a mother experiencing severe depression.[6]

Mothers of young children living in poverty are particularly affected by depression. Among mothers with a major depressive disorder, effects on daily functioning are greater for low-income than for higher-income mothers, with 70 percent compared to 54 percent, respectively, stating that the depression severely or very severely affects their daily activities.[7]

With respect to deeply poor families (those with incomes under half the poverty level), additional evidence of the high incidence of depression prior to the implementation of the ACA comes from several studies. Disconnected single mothers are those who are neither working nor on cash assistance, live in deep poverty, and average just over $9,000 in annual household income for all family members. These women had high rates of maternal depression that were far greater than those of other impoverished groups.[8] A review of home visiting program reports aimed at poor and high-risk mothers with young children found the rates of maternal depression ranging from 29 percent to 61 percent in each study.[9]

Effects of Maternal Depression on Young Children

States that choose to extend Medicaid coverage to parents living in poverty provide direct help to children by enabling them to get better care from healthier parents. Untreated maternal depression negatively affects children, particularly young children. Strong, consistent evidence indicates that a mother's untreated depression undercuts children's healthy development, posing risks to learning, success in school, and adult success.

The effects of maternal depression can be lifelong. Research indicates that maternal depression changes a child's brain chemistry and disrupts the child's stress response system, leading to both physical and mental health conditions later in life.[10] Children with depressed mothers are more likely to develop behavioral problems, social disorders, and learning disabilities. A thorough review of the research by the National Research Council and Institute of Medicine finds that maternal depression endangers young children's cognitive, socio-emotional, and behavioral development, as well as their educational and employment opportunities in their lifetime.[11]

Treating Maternal Depression to Improve Parenting and Reduce Child Poverty

Treating maternal depression is a crucial step to ensure that parents have the ability to nurture their children's healthy development and put them on track to escape poverty. A variety of safe and effective tools exist for treating adults with depression, including pharmacotherapies, psychotherapies, behavioral therapies, and alternative medicines.[12] Both medication and cognitive behavioral therapies, with modifications such as support for child care, have proven particularly effective for poor, minority women.[13] For some mothers, treating depression to remission may be sufficient to strengthen parenting capacity and improve children's outcomes.[14] Others may need additional supports, such as direct parenting intervention.[15] Children can show significant improvement on a range of outcomes, including measures of development and functioning, behavior problems, and mental health problems, after successful treatment of mothers.[16]

Despite improvements since the depth of the Great Recession, more than one in five children (21.1 percent) live in poverty. About 9 percent of children (or 6.5 million) are "deeply poor" and live in families with incomes under half of the poverty level (50 percent of the FPL, or $10,080 annual income for a family of three in 2016). Young children are the most likely to be poor, and there is evidence that poverty at an early age is particularly damaging. Almost 24 percent of children under the age of 5, or 4.7 million, were poor in 2014, as were almost one in four (24.4 percent) of infants (birth to age 1).[17]

Treating maternal depression is crucial to improving parenting and getting children's development back on track for school and adult success, including escaping poverty. For the general population, depression predicts the following: difficulty getting and keeping a job and greater work disability in the short term, lower income and more unemployment over time, and increased absenteeism and reduced productivity among those who have jobs.[18] Treatment of depression can improve work productivity and decrease absenteeism.[19] For poor mothers specifically, treatment combined with employment services can help them earn higher wages, according to several rigorous experiments.[20]

Uninsured Mothers Can't Get Access to Proven Treatment

While depression is highly treatable, many low-income mothers do not receive treatment. Based on 2008-2010 data from the National Survey of Drug Use and Health, more than one-third (37 percent) of low-income mothers with young children who have had a major depressive disorder in the last year do not receive any treatment (talk therapy or prescription medication), compared to one-quarter (25 percent) of their higher-income counterparts.[21] While some people only experience one instance of depression, many others (30-50 percent) experience chronic or recurrent depression requiring the need for long-term support or treatment.[22]

Many mothers face financial barriers to health coverage and appropriate mental health treatment. A study in 2014 found that one in five mothers (23 percent) with the greatest mental health care needs who reported being in moderate or severe psychological distress are uninsured. Two in five mothers (41.5 percent) cite the high cost of health insurance as a reason they lack coverage.[23] Low-income, uninsured parents report high rates of unmet need due to cost, including forgoing medical care (16.2 percent), prescription medication (19.2 percent), and mental health care (5.3 percent).[24] Uninsured parents report additional financial hardships, including running out of food, being unable to pay rent, or having trouble with unexpected bills.[25]

Health insurance coverage, particularly Medicaid, improves low-income women's access to care. Two-thirds (67 percent) of low-income mothers with young children who have health insurance receive treatment for their depression, compared to only half (51 percent) of uninsured low-income mothers. Among insured low-income mothers with depression, mothers with Medicaid and mothers with private/other health insurance had near comparable rates of treatment; 65 percent of mothers with Medicaid received treatment, compared to 70 percent of mothers with private/other health insurance.[26]

When States Don't Expand Medicaid, Poor Mothers Don't Have Coverage

Medicaid is a very important source of coverage for low-income mothers, and many more of them would be eligible if all states expanded Medicaid. In the 19 states that have refused federal funds to expand Medicaid coverage, 2.9 million adults with incomes below the poverty level fall into a coverage gap, including 500,000 mothers who are currently ineligible for Medicaid or premium tax credits.[27] The coverage gap is made up of people of color (55 percent), women (52 percent), and adults in a working family (62 percent). Most people in the coverage gap (90 percent) live in a Southern state.[28]

Uninsured mothers are more likely to be Hispanic (47 percent of uninsured mothers), middle-aged (45 percent between 35 and 49 years old), have a child under the age of 5 (48 percent), and live in the South (52 percent).[29]

Low-Income Parents Would Benefit from Medicaid Expansion

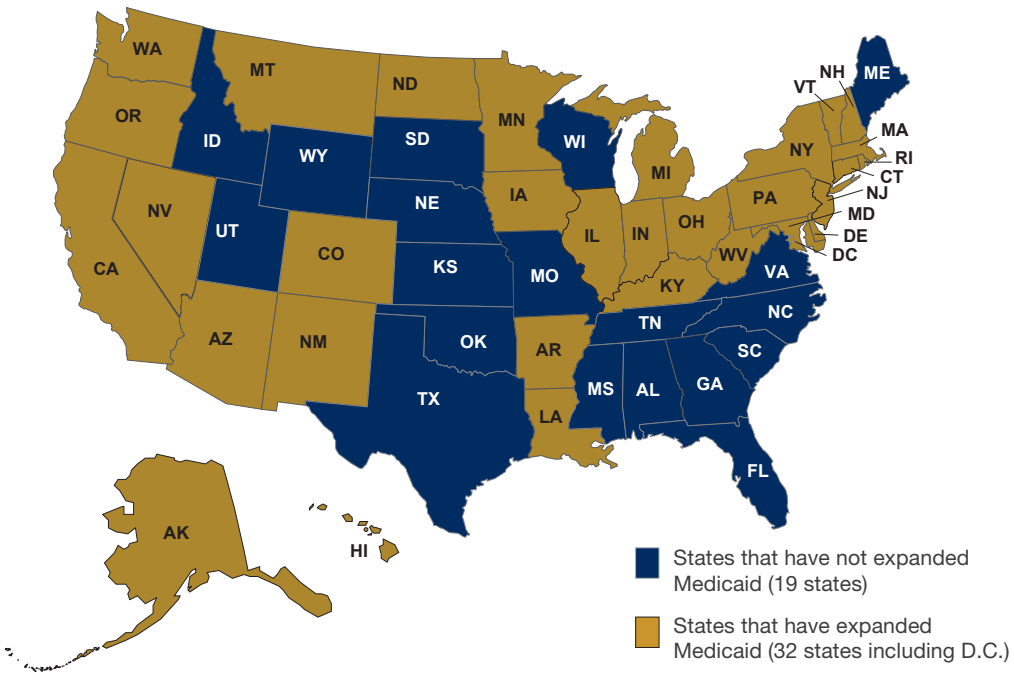
In states that have yet to adopt the Medicaid expansion, only extremely poor parents are eligible for public coverage; many parents living in poverty are excluded from Medicaid coverage. In the 19 states that have elected not to expand Medicaid (as of May 2016), the

median upper income eligibility limit for parents is 44 percent of the FPL ($8,870 annually for a family of three in 2016).[30]

Although several of the non-expansion states have the largest populations of uninsured parents, eligibility levels in these states remain below 50 percent of the poverty level: Eligibility levels in both Texas and Alabama are 18 percent of the FPL ($3,629 annual income for a family of three in 2016); in Florida, they are 34 percent of the FPL ($6,854 annually); in Georgia, 37 percent of the FPL ($7,470 annually); in Virginia, 39 percent of the FPL ($7,862 annually); and in North Carolina, 44 percent of the FPL ($8,870 annually).[31] Six states (Texas, Alabama, Florida, Georgia, Virginia, and North Carolina) are home to three-fourths (74 percent) of all adults in the U.S. who fall into the coverage gap.[32] (See Figure 2 on page 7.)

In addition to expanded Medicaid eligibility, premium tax credits established by the ACA to help purchase insurance in the health insurance marketplaces are available to individuals with income between 100 and 400 percent of the FPL. Parents in the 19 non-expansion states are not eligible for Medicaid or for premium tax credits if their incomes exceed the current Medicaid eligibility threshold but remain below 100 percent of the poverty level ($20,160 annual income for a family of three).

Figure 1. 19 States Have Refused Federal Funds to Expand Medicaid Coverage



Note: Wisconsin covers adults up to 100 percent of FPL, but has not expanded Medicaid coverage through the ACA.

Source: Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts (July 7, 2016), available at http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

Low-Income Pregnant Women Would Benefit from Medicaid Expansion

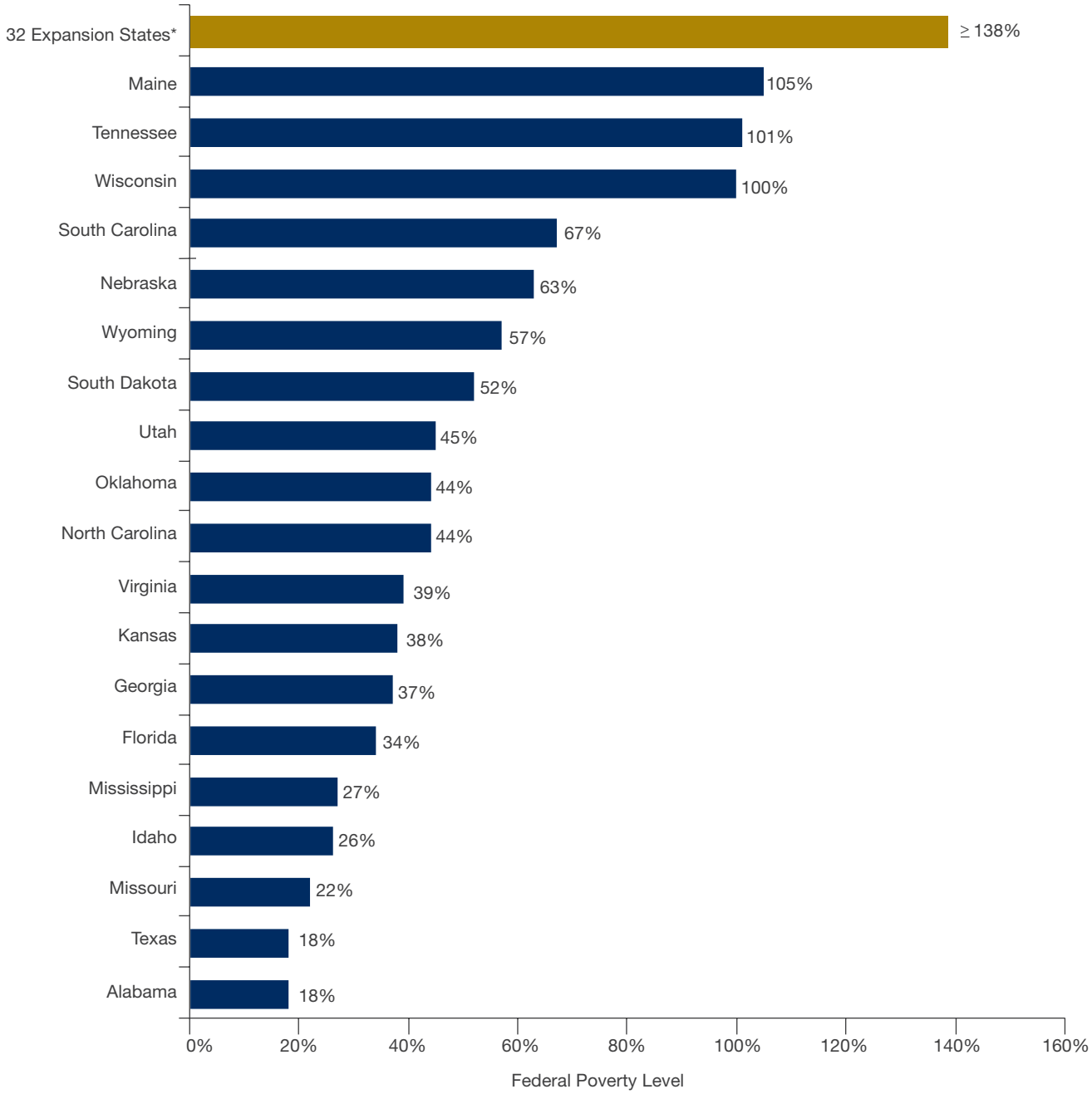
Income eligibility limits for coverage are higher for pregnant women than for other parents, but coverage for pregnant women ends 60 days after birth. This short period of time is not sufficient to treat depression identified during the postpartum period and provides no support for identifying and treating depression among mothers with infants, toddlers, and preschoolers beyond the first two months of life. Federal law requires all states to cover pregnant women in Medicaid with incomes at or below 138 percent of the FPL ($27,821 annual income for a family of three in 2016) and also gives states the option to extend Medicaid coverage to pregnant women with income up to or above 185 percent of the FPL ($37,296 annual income).[33] Although states are only required to provide pregnancy-related services for women covered through this eligibility pathway, most states (45 states) offer full Medicaid benefits to pregnant women.[34]

As such, most mothers are eligible to receive services for at least 60 days after birth, but this is not enough. For 30 to 50 percent of adults with depression, the disorder becomes a chronic or recurrent disorder.[35] New moms need continued eligibility beyond 60 days to ensure adequate treatment.

Recognizing the importance of maternal health for a child's health, the U.S. Centers for Medicare and Medicaid Services (CMS) has taken steps to increase identification of maternal depression. New guidance allows states to screen for maternal depression during a well-child visit, a best practice as defined by the American Academy of Pediatrics (AAP). In some cases, when deemed directly beneficial for the child, a pediatrician can even provide limited treatment for maternal depression as part of Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) treatment.[36]

However, this is still not enough to fully meet the needs of mothers with depression. Mothers not eligible for Medicaid coverage or who are uninsured will not receive comprehensive treatment. If a pediatrician diagnoses a woman who has pregnancy-related coverage with depression and she is beyond the 60-day coverage period, she will likely not have Medicaid coverage to get needed treatment. In states that have not expanded Medicaid, low-income pregnant women with incomes over the state's current parent eligibility level are likely to face disruptions in care as they transition from pregnancy-related Medicaid coverage to another source of coverage or more likely lose coverage altogether.[37]

Figure 2. Medicaid Income Eligibility Levels for Parents



* The 32 states (including D.C.) that expanded Medicaid and provide Medicaid to parents with incomes at or above 138% of the FPL are Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia. A few of these states covered adults before they began receiving the enhanced match in 2014. Wisconsin is not included as an expansion state as it does not accept the enhanced match.

Source: T. Brooks et al., "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey," Georgetown University Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured (January 2016), available at http://ccf.georgetown.edu/wp-content/uploads/2016/01/report-medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey.pdf.

Medicaid Expansion Will Promote Depression Screening and Treatment for Mothers Who Now Fall Through the Gaps

Medicaid expansion provides an opportunity to improve access to care for mothers suffering from depression and to improve the lives of families across the country. In states that have expanded Medicaid, millions of newly eligible Medicaid beneficiaries now have access to a broad set of health care services, including preventive services, treatment and screening for mental health and substance use disorders, behavioral health treatments, prescription drugs, and chronic disease management. States that have expanded Medicaid are required to provide the newly eligible population of low-income parents and adults benefits that include 10 comprehensive health service categories, including behavioral health treatment.[38]

New federal regulations ensure that Medicaid plans provide enrollees treatment for mental health and substance use disorders, with broad access and limited cost-sharing. Benefits must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA), which sets guidelines for patients' access to mental and behavioral health services and requires Medicaid plans to offer the same coverage for mental health and substance use disorders as for other physical disorders that require medical and surgical procedures.[39] In 2016, CMS released a long-awaited final rule to expand mental health and substance use disorder benefits and parity in Medicaid.[40]

Medicaid Offers Financial Protections for Mothers in Medicaid Expansion States

Federal guidelines limit out-of-pocket costs for families in Medicaid and do not allow states to charge premiums to Medicaid enrollees with income under 150 percent of the FPL without a waiver. States have flexibility to impose nominal cost-sharing (including copayments, coinsurance, deductibles or similar charges) on the Medicaid expansion population within federal guidelines. Preventive care and screenings for depression are covered under essential health benefits, and beneficiaries cannot be charged for these services. Behavioral health treatments, such as those mentioned earlier, are covered with little or nominal cost. The cost of a prescription drug treatment cannot exceed $8.[41]

Expanding Medicaid Provides Affordable Services to Mothers

Compared to uninsured adults, adults with Medicaid coverage are more likely to have a usual source of care, visit a doctor for a checkup, and access specialty care.[42] New research indicates that Medicaid expansion has not only resulted in improved access to medical benefits but has also resulted in improved access to behavioral health treatment for newly eligible enrollees.[43]

Expanding Medicaid Increases Access to Treatment, Reduces Rates of Depression

Several studies provide evidence that expanding Medicaid is an effective tool in reducing rates of depression. Medicaid coverage is associated with fewer people experiencing symptoms of depression—in part due to increased access to screening and treatment as well as the increased financial stability that Medicaid provides families.[44] Increasing Medicaid eligibility for parents in the late 1990s and early 2000s led to a 20 percent decline in the number of parents

experiencing moderate psychological distress.[45] In Oregon, there was a 30 percent decline in the rate of depression in the population made newly eligible for Medicaid.[46]

According to recent projections, Medicaid expansion in states that have opted out of the expansion would result in 371,000 fewer individuals (includes low-income parents and childless adults) experiencing symptoms of depression and 540,000 more people reporting good, very good, or excellent health.[47] Urban Institute researchers predict that if all states expanded Medicaid there would be a 15 percent decline in the share of low-income parents experiencing moderate psychological distress.[48]

Additional evidence indicates that expanding Medicaid coverage would result in more parents gaining access to effective treatments for depression and reducing unmet need.[49] In Oregon, Medicaid increased preventive service use—there was a 23.8 percentage point increase in enrollees having a usual place of care, an 11.4 percentage point increase in enrollees receiving all needed care in the last year, and a 4.5 percentage point reduction in catastrophic out-of-pocket medical expenses.[50]

Mental Health Treatment Leads to Public Health Program Savings

Treating depression can improve both the mental and physical health of mothers. Depression occurs in mothers suffering from other physical, mental, or behavioral health disorders, including heart disease, diabetes, stroke, eating disorders and substance abuse.[51] When mothers' depression is in remission, studies have shown that they better manage their physical health conditions. For example, mothers with diabetes who are being treated for depression are more likely to comply with their diet and manage their medication better, suggesting cost savings to the public health system.[52]

States can benefit from a two-generational approach to treating maternal depression. Treatment for mothers who suffer from depression can mitigate the development of emotional and behavioral disorders by their children, thus reducing the burden on public health systems.[53] Mothers with depression are better able to manage their children's health, particularly for chronic conditions. Several studies have shown that treating mothers for depression leads to improved management of their child's asthma, reducing costly hospitalizations and emergency department visits.[54]

Urban Institute researchers predict that if all states expanded Medicaid there would be a 15 percent decline in the share of low-income parents experiencing moderate psychological distress.

Medicaid Expansion and Potential State Savings in Behavioral Health

Expansion states have seen significant savings as they use federal funds to substitute state funds that have previously been spent on newly eligible persons through state-based behavioral health programs.[55] This frees up state general funds for additional mental health services and supports such as home visiting services.[56]

A recent study found that financial security for providers in Medicaid expansion states is providing additional benefits and better care to parents with behavioral health issues. For example, primary health clinics are hiring new mental health providers and integrating their work into primary health services, allowing safety-net providers in Medicaid expansion states to provide more services and better-coordinated care than in non-expansion states.[57]

Conclusion

Medicaid expansion for low-income mothers can greatly improve women's access to treatment for depression, which is vital to children's healthy development. Children's healthy development is highly dependent on the physical and mental health of their parents, yet many children, particularly low-income children, are being raised by parents with unmet mental health needs.

Many poor and uninsured mothers go without treatment because they lack health coverage and the financial resources to obtain effective treatments. The extremely low Medicaid income eligibility levels for parents in states that have not yet expanded Medicaid leave many parents without an affordable health coverage option. About 500,000 uninsured mothers fall into the coverage gap—with incomes too high for Medicaid coverage and too low for marketplace premium tax credits. Extending Medicaid coverage to low-income mothers would help increase screening, identification, and treatment of maternal depression—thereby promoting young children's healthy development and family economic security. Many states that have accepted the Medicaid option have found that Medicaid coverage has helped increase access to mental health services and removed some of the financial barriers that had previously discouraged mothers from seeking help when they need it.

Improving the physical and mental well-being of mothers helps them better fulfill their caregiving role for their children. If more states were to accept Medicaid expansion funding, more mothers would gain access to maternal depression screening and treatment and more children would have improved opportunities to reach their full potential.

Endnotes

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[4] For the purpose of this analysis, the 32 states (including D.C.) that expanded Medicaid are Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia. A few of these states covered adults before they began receiving the enhanced match in 2014. Wisconsin is not included as an expansion state as it does not accept the enhanced match. Louisiana expanded Medicaid in January of 2016. Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts (July 7, 2016), available at http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

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[30] T. Brooks et al., "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey," Georgetown University Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured (January 2016), available at http://ccf.georgetown.edu/wp-content/uploads/2016/01/report-medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey.pdf.

[31] T. Brooks et al., op. cit.

[32] R. Garfield and A. Damico, op. cit.

[33] Federal law requires that states cover pregnant women up to whichever income standard is higher: 1) 133 percent of the FPL, or 2) a state-established income limit not to exceed 185 percent of the FPL, in place as of December 19, 1989 or July 1, 1989 under authorizing legislation. Some states may cover pregnant women above 185 percent of the FPL if they provide coverage to certain eligible populations above 185 percent of the FPL or if they have a waiver to cover pregnant women at higher incomes. 42 C.F.R. § 435.116. Most states have taken advantage of this flexibility, with the median eligibility level slightly higher in the 32 states that have expanded Medicaid than in the 19 states that have not expanded coverage to all low-income adults. States may also provide coverage to pregnant women at higher income eligibility levels through the Children's Health Insurance Program (CHIP). Additionally, states may submit a State Plan Amendment (SPA) to cover pregnant women in Medicaid/CHIP who may otherwise be ineligible for coverage based on their immigration status (ICHIA) using state funds. See T. Brooks et al., op. cit.

[34] States have the option of offering full Medicaid benefits or limited benefits to pregnant women. Forty-five states provide full Medicaid benefits—as opposed to prenatal and pregnancy-related benefits—to pregnant women eligible for Medicaid. Of the seven states that provided more limited benefits to pregnant women, CMS determined that three pregnancy-related Medicaid programs do not meet minimum essential coverage standards. C. Mann, "Minimum Essential Coverage," Centers for Medicare & Medicaid Services SHO# 14-002 (November 7, 2014), available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf; "Medicaid Secretary-approved Minimum Essential Coverage," Centers for Medicare & Medicaid Services (February 16, 2016), available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/state-mec-designations.pdf.

[35] M. England and L. Sim, op. cit.

[36] See details on recent guidance from CMS that highlights policy options for screening and treating maternal depression in S. Schmit and C. Walker, "New CMS Guidance Highlights Policy Options for Screening and Treating Maternal Depression," Washington: CLASP (May 2016), available at http://www.clasp.org/issues/child-care-and-early-education/in-focus/new-cms-options-screening-and-treating-maternal-depression. The ability to reimburse the screening as part of EPSDT may be especially important in states that have not expanded Medicaid because mothers without insurance may not encounter a medical professional other than their child's pediatrician. In these states, the screening will likely identify many mothers who need treatment for their depression yet are not eligible for Medicaid as a resource to support that treatment. For mothers who are not eligible for Medicaid themselves and who are uninsured, the ability to receive reimbursable treatment when provided jointly with their child opens up new possibilities for treating maternal depression for low-income women.

[37] T. Brooks et al., op. cit.

[38] The 10 categories are: 1) Ambulatory patient services; 2) Emergency services; 3) Hospitalization; 4) Maternity and newborn care; 5) Mental health and substance use disorders, including behavioral health treatment; 6) Prescription drugs; 7) Rehabilitative and habilitative services and devices; 8) Laboratory services; 9) Preventive and wellness services and chronic disease management; and 10) Pediatric services, including oral and vision care. 45 C.F.R. § 156.110.

[39] 42 C.F.R. § 440.345.

[40] 42 C.F.R. § 438, 440, 456, 457.

[41] For people with incomes below 150 percent of the FPL, allowable copayments are restricted to "nominal" amounts for services and "minimal" amounts for prescription drugs and non-emergency use of the emergency department. Total cost-sharing—including premiums and copayments—may not exceed 5 percent of family income ($1,008 for a family of three in 2016) for all enrolled members of the family. States cannot impose cost-sharing for preventive services defined as essential health benefits in ABPs. In order to impose higher cost-sharing than otherwise allowed by Medicaid, a state seek federal approval under Section 1916(f) demonstration waiver authority. 45 C.F.R. § 447.

[42] J. Paradise, B. Lyons, and D. Rowland, "Medicaid at 50," Washington: Kaiser Commission on Medicaid and the Uninsured, May 6, 2015, available at http://kff.org/medicaid/report/medicaid-at-50/.

[43] U.S. Government Accountability Office, Options for Low-Income Adults to Receive Treatment in Selected States, Report no. GAO-15-449 (June 2015), available at http://www.gao.gov/assets/680/670894.pdf.

[44] K. Baicker et al., op. cit.; S. Dickman, D. Himmelstein, D. McCormick, and S. Woolhandler, "Opting out of Medicaid Expansion: The Health and Financial Impacts" Health Affairs Blog, January 30, 2014, available at http://healthaffairs.org/blog/2014/01/30/opting-out-of-medicaid-expansion-the-health-and-financial-impacts/.

[45] S. Morrow, G. Kenney, S. Long, D. Goin, op. cit.

[46] The Oregon Health study is an experiment that began in 2008 when the state randomly selected uninsured participants to apply for Medicaid coverage creating a randomized, controlled trial of a social policy. K. Baicker et al., op. cit.

[47] J. Dey et al., Benefits of Medicaid Expansion for Behavioral Health, Department of Health & Human Services. ASPE (March 28, 2016), available at https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf.

[48] S. Morrow, G. Kenney, S. Long, D. Goin, op. cit.

[49] H. Wen, B. Druss, and J. Cummings, "Effect of Medicaid Expansions on Health Insurance Coverage and Access to Care among Low-Income Adults with Behavioral Health Conditions," *Health Services Research* 50, no. 6 (December 2016): 1787-1809.

[50] K. Baiker et al., op. cit.

[51] Mental Health America, "Co-Occurring Disorders and Depression," accessed July 1, 2016, available at http://www.mentalhealthamerica.net/conditions/co-occurring-disorders-and-depression.

[52] L. Lamberg, "Treating Depression in Medical Conditions May Improve Quality of Life," *Journal of the American Medical Association* 276, no. 11 (September 1996): 857-858, available at http://jama.jamanetwork.com/article.aspx?articleid=407850.

[53] W. R. Beardslee, T. R. G. Gladstone, and E. E. O'Connor. 2011, "Transmission and Prevention of Mood Disorders among Children of Affectively Ill Parents: A Review," *Journal of the American Academy of Child and Adolescent Psychiatry* 50, no. 11 (November 2011): 1098–109; C. A. Lesesne, S. N. Visser, and C. P. White, "AttentionDeficit/Hyperactivity Disorder in School-Aged Children: Association with Maternal Mental Health and Use of Health Care Resources," *Pediatrics* 111, no. 5 (May 2003): 1232–37.

[54] C. D. Perry, "Does Treating Maternal Depression Improve Child Health Management? The Case of Pediatric Asthma." *Journal of Health Economics* 27, no. 1 (2008): 157–73; S. J. Bartlett, K. Kolodner, A. M. Butz, P. Eggleston, F. J. Malveaux, and C. S. Rand, "Maternal Depressive Symptoms and Emergency Department Use among Inner-City Children with Asthma," *Archives of Pediatrics and Adolescent Medicine* 155, no. 3 (2001): 347–54.

[55] Medicaid is jointly financed by both state funds and the federal government. The federal government pays for a majority of Medicaid's costs in all states, as determined by the Federal Medical Assistance Percentage (FMAP). Should the remaining state choose to extend Medicaid to adults with incomes up to 138 percent of the FPL, billions in federal funding will cover 100 percent of the costs for this new coverage through 2016 and no less than 90 percent after that. See, for example, J. Cross-Call, "Medicaid Expansion Is Producing Large Gains in Health Coverage and Saving States Money," Washington: Center on Budget and Policy Priorities (April 2015), available at http://www.cbpp.org/research/health/medicaid-expansion-is-producing-large-gains-in-health-coverage-and-saving-states.

[56] D. Bachrach, P. Boozang, A. Herring, and D. G. Reyneri, "States Expanding Medicaid See Significant Budget Savings and Revenue Gains: Early Data Shows Consistent Economic Benefits Across Expansion States," State Health Reform Assistance Network, March 2016, available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097.

[57] J. Hoadley and A. Searing, "The Ripple Effects of Medicaid Expansion," Health Affairs Blog, June 7, 2016, available at http://healthaffairs.org/blog/2016/06/07/the-ripple-effects-of-medicaid-expansion/.

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