Coverage Effects of Oregon's Healthier Oregon All-Ages Expansion and the Co-Occurring OHP Bridge Program: Synthetic-Control Evidence from the ACS, 2018-2024

Abstract

Background: On July 1, 2023, Oregon's Healthier Oregon expansion extended full Oregon Health Plan benefits to all income-eligible residents regardless of immigration status. Before that date, Healthier Oregon already covered ages 0-25 and 55+. The newly exposed adult target band is therefore ages 26-54.

Methods: This study built a 2018-2024 ACS state-year panel for low-income noncitizen adults ages 26-54 (primary) and ages 19-64 (sensitivity), with 1-200% federal poverty line (FPL) household income. Outcomes are uninsurance, Medicaid or means-tested public coverage, any public coverage, and private coverage. The primary estimator is ridge-augmented synthetic control (ASCM) with five pre-treatment years (2018-2022), 2023 as a transition year, and 2024 as the primary post-treatment year. The donor pool excludes states with comparable adult immigrant-coverage policies. The 2024 post-period also contains OHP Bridge, a Basic Health Program for adults up to 200% FPL with eligible citizenship or immigration status that began July 1, 2024; the manuscript treats the 2024 estimate as the joint effect of Healthier Oregon plus OHP Bridge.

Results: For the primary sample (ages 26-54, 1-200% FPL), the 2024 ASCM estimates are: uninsurance 21.0 percent versus an ASCM counterfactual of 46.4 percent (gap -25.4 pp); Medicaid or means-tested public coverage 43.8 percent versus 24.5 percent (gap +19.3 pp); any public coverage 45.2 percent versus 23.8 percent (gap +21.4 pp); private coverage 40.5 percent versus 28.9 percent (gap +11.7 pp). Direction is preserved under small-cell donor screens, leave-one-donor-out for the top six donor weights, and the legacy 19-64 sample. The placebo-in-space rank p-value for uninsurance is 0.068 (legacy 19-64 panel), which is suggestive but not definitive.

Conclusions: The newly exposed cell (ages 26-54) shows a large 2024 reduction in uninsurance and a large rise in Medicaid coverage for low-income ACS noncitizens, but the 2024 estimate is the joint effect of Healthier Oregon and the July 2024 OHP Bridge program and is based on a single post-treatment ACS year with an exact pre-fit ASCM design. The estimates should be interpreted as a short-post-period public-data screen with explicit inference limits, not as a mature causal estimate.

Introduction

State-funded coverage programs that include adults regardless of immigration status are an increasingly important response to federal Medicaid eligibility

restrictions. KFF and the National Immigration Law Center track a growing set of states using state funds to cover noncitizen adults, but adult coverage remains concentrated in a small set of states.[KFF 2024; NILC 2026] Oregon's Healthier Oregon expansion provides a useful policy case because it created a discrete eligibility change at a known date for an identifiable adult target population.

The Oregon Health Authority documents two specific facts that govern this paper's design choices. First, as of July 1, 2023, people of all ages meeting income and other criteria qualify for full Oregon Health Plan benefits regardless of immigration status. Second, prior to that date Healthier Oregon already covered ages 0-25 and 55+; the newly exposed adult age band is therefore approximately ages 26-54.[OHA Healthier Oregon] The current paper takes that newly exposed band as the primary analytic sample. Ages 19-25 and 55+ are reported as sensitivity strata only.

A separate Oregon policy also affects the 2024 ACS post year. OHP Bridge, a Basic Health Program for adults up to 200% FPL with eligible citizenship or immigration status, began July 1, 2024. Because the ACS noncitizen recode (CITIZEN == 3) includes lawfully present noncitizens as well as undocumented residents, the 2024 coverage change for low-income noncitizens cannot be cleanly separated from OHP Bridge. We therefore treat the 2024 estimate as the joint effect of Healthier Oregon plus OHP Bridge and report a Bridge-net sensitivity using 2023 as the target year.

This paper asks whether the joint Healthier-Oregon-plus-OHP-Bridge change is visible in public 2024 ACS coverage measures for low-income ACS noncitizens in the newly exposed age band, against a synthetic-control benchmark of donor states that did not implement comparable adult immigrant-coverage policies during the analysis window. The contribution is methodological honesty and timing: a short-post-period public-data screen that interprets a 2024 effect for the newly exposed band against a transparent donor-policy ledger and explicit co-occurring-policy disclosure.

Data and Methods

The analysis uses the IPUMS ACS 1-year extract for 2018-2024 (12,153,788 person-year records) shared with sibling immigrant-coverage analyses. Person-level records are kept if the respondent lives in a household (group quarters 1 or 2), is a noncitizen (CITIZEN == 3), has family income between 1 and 200 percent of the federal poverty line, and falls in the analytic age range.

The primary age band is ages 26-54, the cell newly exposed at the July 1, 2023 Healthier Oregon expansion. Sensitivity bands are ages 19-64 (legacy v1 estimand; mixes newly exposed 26-54 with already-open 19-25 and 55+), ages 19-25 (already covered pre-2023), and ages 55-64 (already covered pre-2023). FPL bands are 1-200%, 1-138%, and 139-200%.

Person-level records are collapsed to state-year cells using ACS person weights, producing a 51-state by 7-year panel for each stratum. Outcomes are uninsurance (1 - HCOVANY), Medicaid or means-tested public coverage (HINSCAID), any public coverage (HCOVPUB), and private coverage (HCOVPRIV), all recoded to 0/1.

The treated state is Oregon. The primary donor pool excludes the seven states with comparable adult immigrant-coverage policies during the analysis window (CA, IL, NY, WA, CO, MN, DC). Pre-treatment years are 2018-2022 (five years), 2023 is a transition year because Healthier Oregon launched July 1, and 2024 is the primary post-treatment year.

For each outcome, donor weights minimize squared pre-treatment differences between Oregon and a convex combination of donor states.[Abadie et al. 2010] A ridge-augmented correction then adjusts for residual pre-treatment fit when the treated unit is outside the donor convex hull.[Ben-Michael et al. 2021] The headline numbers are the ASCM gap, defined as Oregon's observed value minus the ASCM counterfactual, and pre-treatment RMSPE.

Inference is screening-oriented. With five pre-treatment years and 43 donor states, ASCM achieves near-zero pre-treatment RMSPE for every outcome in the primary stratum. This is a known short-panel overfit pattern, not evidence of causal closure. The reported placebo-in-space rank p-value of 0.068 (legacy 19-64 sample for uninsurance) is therefore reported as suggestive, not definitive.

Co-occurring Oregon policy disclosure

OHP Bridge began July 1, 2024 and covers adults up to 200% FPL with eligible citizenship or immigration status. ACS CITIZEN == 3 includes lawfully present noncitizens (LPRs, visa holders, refugees, asylees) as well as undocumented residents. The 2024 ASCM estimate is therefore the joint effect of Healthier Oregon (all immigration statuses) plus OHP Bridge (eligible immigration status only) on low-income noncitizens. A Bridge-net sensitivity uses 2023 as the target year (transition year), which captures only the partial 2023 exposure window for Healthier Oregon and excludes Bridge.

Estimator-comparison diagnostics

We report four supplementary in-script estimator-comparison diagnostics that share the project's Python codebase: an unweighted donor-mean DiD, an approximate SDID-style adjustment (SCM-weighted post counterfactual plus average pre-period SCM gap; this is not the formal Arkhangelsky et al. 2021 SDID estimator), a ridge-regularized two-way fixed-effect imputation (a TWFE-imputation diagnostic, not formal Borusyak-Jaravel-Spiess), and an approximate interactive-fixed-effects diagnostic based on a rank-2 SVD of the donor matrix plus a ridge fit (not the formal Xu 2017 gsynth estimator). These are direction-screening diagnostics, not substitutes for formal SDID, generalized synthetic control, or matrix-completion implementations.

We also re-estimate the headline 2024 effect on the primary 26-54 stratum using two formally implemented estimators on the same panel and donor pool: (a) `synthdid::synthdid_estimate` (Arkhangelsky et al. 2021; R package synthdid v0.0.9), the canonical synthetic difference-in-differences estimator, with placebo-permutation standard errors across the 43 donors; and (b) `pysyncon` v1.5.1's `Synth` class, the canonical Abadie-Diamond-Hainmueller synthetic-control estimator. The formal-estimator comparison is the v3 upgrade flagged in the v2 iteration memo as a v3 requirement.

Results

For the primary stratum (ages 26-54, 1-200% FPL), Table 2 reports the 2024 ASCM estimates. Uninsurance was 21.0 percent versus an ASCM counterfactual of 46.4 percent (-25.4 percentage points). Medicaid or means-tested public coverage was 43.8 percent versus 24.5 percent (+19.3 pp). Any public coverage was 45.2 percent versus 23.8 percent (+21.4 pp). Private coverage was 40.5 percent versus 28.9 percent (+11.7 pp).

In the legacy 19-64 sample, the uninsurance gap is -19.7 pp and the Medicaid gap is +13.6 pp. The 19-64 estimates are smaller in magnitude than the 26-54 estimates because they include ages 19-25 and 55+, which were already eligible for Healthier Oregon before July 1, 2023.

In the Bridge-net sensitivity (target year 2023; pre-Bridge), the uninsurance gap is -6.5 pp and the Medicaid gap is +3.2 pp for the 26-54 stratum. These are partial-year transition effects and should be interpreted as a lower bound on the Healthier-Oregon-only signal, not as a clean policy estimate.

Robustness checks preserve the direction of the primary 26-54 results. Small-cell donor screening (dropping donors with any 2018-2024 ACS state-year cell below n = 10, 20, 30, or 50) leaves the uninsurance gap between -23 and -30 pp and the Medicaid gap between +17 and +21 pp. Leave-one-donor-out for the top six donor weights on the 26-54 stratum moves the uninsurance gap by at most 2 percentage points and the Medicaid gap by at most 1.6 percentage points.

The placebo-in-space rank p-value for uninsurance (legacy 19-64 panel) is 0.068. The placebo distribution exhibits the same near-zero pre-RMSPE pattern as Oregon at several donor states with small 2024 cell sizes; we therefore treat the placebo as suggestive of a real signal, not as definitive inference.

Formal synthdid and Synth corroboration

On the primary 26-54 stratum the formal `synthdid` estimator (Arkhangelsky et al. 2021) returns a 2024 uninsurance gap of -24.6 percentage points (placebo SE 9.3 pp, p = 0.008) and a Medicaid gap of +15.3 pp (placebo SE 11.1 pp, p = 0.17). The formal pysyncon `Synth` estimator returns -22.7 pp for uninsurance and +14.7 pp for Medicaid. The uninsurance signal

corroborates the approximate-diagnostic ASCM headline of -25.4 pp in direction and rough magnitude, and the formal placebo p of 0.008 is materially sharper than the approximate-diagnostic placebo rank p of 0.068. The Medicaid signal corroborates in direction but attenuates 4-5 pp relative to the approximate-diagnostic ASCM, and the formal placebo p of 0.17 is not statistically significant at conventional thresholds. A reasonable consensus interval across the three estimators is -23 to -25 pp for uninsurance and +15 to +19 pp for Medicaid. Full estimator comparison and donor weights are in `analysis/robustness/formal_synthdid_26_54.md`.

Discussion

The newly exposed adult cell (ages 26-54) shows a large 2024 reduction in uninsurance and a large rise in Medicaid coverage for low-income ACS noncitizens in Oregon, relative to a donor-state synthetic control. The direction is consistent with the expected first-stage effect of a state-funded immigrant coverage expansion. The 26-54 primary stratum yields larger and more interpretable effects than the v1 19-64 estimand because it does not mix newly exposed and already-eligible age groups.

Three caveats temper interpretation. First, the 2024 estimate is the joint effect of Healthier Oregon (all immigration statuses) and OHP Bridge (eligible immigration status only). The ACS does not separately identify lawfully present noncitizens, so a clean Healthier-Oregon-only effect is not identifiable in the public extract. We disclose this rather than rebrand it.

Second, the design has a single post-treatment ACS year, five pre-treatment years, and 43 donor states. ASCM achieves near-zero pre-fit for every outcome, which is a known overfit pattern at this panel shape. The leave-one-out, small-cell screen, and donor-policy audit show the direction is stable, but pre-fit alone does not establish causal closure.

Third, ACS citizenship is not documentation status. The estimand is low-income noncitizens, not undocumented residents alone. Private-coverage point estimates rise alongside public coverage; this likely reflects ACS coverage-category overlap, sample composition shifts, or labor-market effects and should not be interpreted as a mechanism for Healthier Oregon.

These limits mean the paper should be read as a short-post-period public-data screen with explicit inference limits, not as a mature causal estimate. A 2025 ACS update will allow a two-post-year specification and a Bridge-vs-no-Bridge contrast inside Oregon, both of which would substantially strengthen identification.

Formal synthdid and pysyncon Synth corroboration of the 26-54 headline addresses one of two v3 upgrades flagged by the audit memo. The second upgrade (a 2025 ACS extension with a Bridge-vs-no-Bridge inside-Oregon contrast) remains outstanding and is the planned next iteration.

Conclusion

Oregon's July 1, 2023 Healthier Oregon expansion and the July 1, 2024 OHP Bridge program together coincide with a large 2024 reduction in ACS uninsurance and rise in Medicaid coverage among low-income noncitizen adults ages 26-54, the newly exposed cell. The direction is stable across small-cell donor screens, top-weight leave-one-out, and the legacy 19-64 sample, but inference is limited by a single post-treatment ACS year, exact pre-fit, and the inability to separately identify the OHP Bridge component in the ACS.

Sources

- Oregon Health Authority. Healthier Oregon. https://www.oregon.gov/oha/OHP/pages/healthier-oregon.aspx
- Oregon Health Authority. OHP Bridge Program. https://www.oregon.gov/oha/HSD/OHP/Pages/Bridge Program.aspx
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- KFF. State Health Coverage for Immigrants and Implications for Health Coverage and Care. 2025-05-29; updated 2025-09-12.
- NILC. Medical Assistance Programs for Immigrants in Various States. 2026-03-30.
- IPUMS USA. Ruggles et al. 2025. https://doi.org/10.18128/D010.V16.0

Appendix

A1. OHP Bridge Co-Occurring Policy Ledger

OHP Bridge Co-Occurring Policy Ledger

Updated 2026-05-16 in response to the 2026-05-15 full-pipeline audit (P1 finding "2024 OHP Bridge is a co-occurring Oregon policy for ACS noncitizens").

Policy

OHP Bridge is a Basic Health Program pathway for adults with household income up to 200% of the federal poverty line who have an eligible citizenship or immigration status. Implementation began July 1, 2024.

- Oregon Health Authority, OHP Bridge program page: https://www.oregon.gov/oha/HSD/OHP/Pages/B Program.aspx
- Oregon Health Authority enrollment reports identify Bridge separately from Healthier Oregon Adult: https://www.oregon.gov/oha/hpa/analytics/pages/medicaid-enrollment.aspx

Why It Matters for This Paper

The analysis estimand is ACS noncitizens. The ACS `CITIZEN == 3` recode includes:

- Undocumented residents
- Lawful permanent residents
- Visa holders, refugees, and asylees

OHP Bridge requires eligible citizenship/immigration status, which includes lawful permanent residents and several visa categories. Healthier Oregon (the treatment of interest) covers adults regardless of immigration status.

Therefore the 2024 ACS coverage change for low-income noncitizens reflects two co-occurring Oregon policies: Healthier Oregon (all immigration statuses) plus OHP Bridge (eligible immigration status only). The 2024 ACS coverage gap cannot be attributed solely to Healthier Oregon.

How the Manuscript Now Handles This

1. **Primary specification (ages 26-54, 1-200% FPL, 2024 post)**: estimates are reported as the combined effect of Healthier Oregon and OHP Bridge on noncitizen adult coverage during the first post-policy ACS year. The manuscript explicitly states this is a joint estimate.
2. **Bridge-net sensitivity**: a pre-2024 specification uses 2023 as the transition year and stops the panel before Bridge implementation. Because Healthier Oregon launched mid-2023 (July 1) and ACS measures coverage at interview, this is a conservative lower bound: it captures only the partial 2023 exposure window. Results in `analysis/robustness/age_fpl_sensitivity.csv`, stratum `ages_26_54_pre2024`.
3. **Bridge-eligibility partition**: the ACS does not separately identify lawful permanent residents from undocumented residents in the public extract, so a clean Bridge-vs-Healthier-Oregon split is not feasible. The manuscript discloses this as a limitation rather than claim to resolve it.

Disclosure Language for the Manuscript

> Two co-occurring Oregon policies operate in the 2024 ACS post-year: the July 1, 2023 Healthier Oregon all-ages expansion (treatment of interest, covers adults regardless of immigration status) and the July 1, 2024 OHP Bridge Basic Health Program (adults up to 200% FPL with eligible citizenship/immigration status). Because ACS noncitizens (CITIZEN == 3) include both undocumented residents and lawfully present noncitizens, the 2024 estimates should be interpreted as the joint effect of both policies on the low-income noncitizen population, not as a clean Healthier Oregon effect. A

pre-2024 Bridge-net specification using 2023 as the target year is reported as a lower-bound sensitivity.

Decision

Do not silently rebrand the 2024 estimate. Disclose Bridge as a co-occurring policy in the abstract, methods, and discussion. Report the Bridge-net sensitivity in the supplement.

A2. Age-Band x FPL ASCM Sensitivity

Age-Band x FPL ASCM Sensitivity

Primary analytic stratum is **ages 26-54, 1-200% FPL** because Healthier Oregon covered ages 0-25 and 55+ before July 1, 2023; only ages 26-54 are newly exposed at the July 1, 2023 expansion. All other strata are reported for transparency.

Stratum	Treated n (target year)	Donors	Outcome	Observed (%)	ASCM cf (%)	Gap (pp)	Pre-RMSPE (pp)
Ages 26-54, 1-200% FPL (PRIMARY)	241	43	Uninsured	21.0	46.4	-25.4	0.0
Ages 26-54, 1-200% FPL (PRIMARY)	241	43	Medicaid	43.8	24.5	+19.3	0.0
Ages 26-54, 1-200% FPL (PRIMARY)	241	43	Any public	45.2	23.8	+21.4	0.0
Ages 26-54, 1-200% FPL (PRIMARY)	241	43	Private	40.5	28.9	+11.7	0.0
Ages 19-64, 1-200% FPL (legacy)	330	43	Uninsured	22.8	42.5	-19.7	0.0

Stratum	Treated n (target year)	Donors	Outcome	Observed (%)	ASCM cf (%)	Gap (pp)	Pre-RMSPE (pp)
Ages 19-64, 1-200% FPL (legacy)	330	43	Medicaid	41.1	27.5	+13.6	0.0
Ages 19-64, 1-200% FPL (legacy)	330	43	Any public	43.1	28.1	+15.0	0.0
Ages 19-64, 1-200% FPL (legacy)	330	43	Private	39.5	31.1	+8.4	0.0
Ages 19-25, 1-200% FPL (already covered pre-2023)	43	41	Uninsured	27.9	43.6	-15.7	2.6
Ages 19-25, 1-200% FPL (already covered pre-2023)	43	41	Medicaid	30.4	22.3	+8.1	0.0
Ages 19-25, 1-200% FPL (already covered pre-2023)	43	41	Any public	34.6	22.7	+11.9	0.0
Ages 19-25, 1-200% FPL (already covered pre-2023)	43	41	Private	38.1	67.8	-29.7	4.1

Stratum	Treated n (target year)	Donors	Outcome	Observed (%)	ASCM cf (%)	Gap (pp)	Pre-RMSPE (pp)
Ages 55-64, 1-200% FPL (already covered pre-2023)	46	38	Uninsured	28.1	38.5	-10.4	0.0
Ages 55-64, 1-200% FPL (already covered pre-2023)	46	38	Medicaid	37.9	35.7	+2.2	0.0
Ages 55-64, 1-200% FPL (already covered pre-2023)	46	38	Any public	40.3	39.5	+0.7	0.0
Ages 55-64, 1-200% FPL (already covered pre-2023)	46	38	Private	34.6	21.2	+13.4	0.0
Ages 26-54, 1-138% FPL	155	43	Uninsured	18.4	47.4	-28.9	0.0
Ages 26-54, 1-138% FPL	155	43	Medicaid	50.9	33.1	+17.8	0.0
Ages 26-54, 1-138% FPL	155	43	Any public	52.6	31.7	+20.9	0.0
Ages 26-54, 1-138% FPL	155	43	Private	36.1	25.9	+10.2	0.0
Ages 26-54, 139-200% FPL	86	43	Uninsured	26.0	44.1	-18.1	0.0

Stratum	Treated n (target year)	Donors	Outcome	Observed (%)	ASCM cf (%)	Gap (pp)	Pre-RMSPE (pp)
Ages 26-54, 139-200% FPL	86	43	Medicaid	29.8	17.9	+12.0	0.0
Ages 26-54, 139-200% FPL	86	43	Any public	30.7	18.4	+12.3	0.0
Ages 26-54, 139-200% FPL	86	43	Private	49.1	39.8	+9.3	0.0
Ages 26-54, 1-200% FPL, pre-2024 only (Bridge-net)	297	43	Uninsured	41.4	47.9	-6.5	0.0
Ages 26-54, 1-200% FPL, pre-2024 only (Bridge-net)	297	43	Medicaid	31.9	28.7	+3.2	0.0
Ages 26-54, 1-200% FPL, pre-2024 only (Bridge-net)	297	43	Any public	31.9	28.6	+3.3	0.0
Ages 26-54, 1-200% FPL, pre-2024 only (Bridge-net)	297	43	Private	28.3	30.2	-1.9	0.0

Notes: Negative uninsurance gaps indicate lower uninsurance than the counterfactual. The pre-2024 stratum (target year 2023) is a Bridge-net specification because OHP Bridge for lawfully present noncitizens up to 200% FPL begins July 1, 2024 and could mix with Healthier Oregon in the ACS 2024 post year.

A3. Small-Cell Donor Stress

Small-Cell Donor Stress

Drops donors with minimum 2018-2024 ACS state-year n below the threshold. VT, AK, ND, SD and similar small-cell states have <30 persons in some years.

Stratum	Min cell n	Donors kept	Donors dropped	Outcome	Observed (%)	ASCM cf (%)	Gap (pp)
Ages 26-54 (primary)	0	43		Uninsured	21.0	46.4	-25.4
Ages 26-54 (primary)	0	43		Medicaid	43.8	24.5	+19.3
Ages 26-54 (primary)	10	41	AK, VT	Uninsured	21.0	46.0	-25.0
Ages 26-54 (primary)	10	41	AK, VT	Medicaid	43.8	26.6	+17.1
Ages 26-54 (primary)	20	35	AK, ME, MT, ND, SD, VT, WV, WY	Uninsured	21.0	49.0	-28.0
Ages 26-54 (primary)	20	35	AK, ME, MT, ND, SD, VT, WV, WY	Medicaid	43.8	22.8	+20.9
Ages 26-54 (primary)	30	34	AK, ME, MT, ND, NH, SD, VT, WV, WY	Uninsured	21.0	50.6	-29.6

Stratum	Min cell n	Donors kept	Donors dropped	Outcome	Observed (%)	ASCM cf (%)	Gap (pp)
Ages 26-54 (primary)	30	34	AK, ME, MT, ND, NH, SD, VT, WV, WY	Medicaid	43.8	25.1	+18.7
Ages 26-54 (primary)	50	34	AK, ME, MT, ND, NH, SD, VT, WV, WY	Uninsured	21.0	50.6	-29.6
Ages 26-54 (primary)	50	34	AK, ME, MT, ND, NH, SD, VT, WV, WY	Medicaid	43.8	25.1	+18.7
Ages 19-64 (legacy)	0	43		Uninsured	22.8	42.5	-19.7
Ages 19-64 (legacy)	0	43		Medicaid	41.1	27.5	+13.6
Ages 19-64 (legacy)	10	42	VT	Uninsured	22.8	43.7	-20.9
Ages 19-64 (legacy)	10	42	VT	Medicaid	41.1	27.4	+13.7
Ages 19-64 (legacy)	20	38	AK, MT, ND, VT, WY	Uninsured	22.8	47.1	-24.3
Ages 19-64 (legacy)	20	38	AK, MT, ND, VT, WY	Medicaid	41.1	27.1	+14.1
Ages 19-64 (legacy)	30	34	AK, ME, MT, ND, NH, SD, VT, WV, WY	Uninsured	22.8	46.0	-23.1
Ages 19-64 (legacy)	30	34	AK, ME, MT, ND, NH, SD, VT, WV, WY	Medicaid	41.1	25.1	+16.0

Stratum	Min cell n	Donors kept	Donors dropped	Outcome	Observed (%)	ASCM cf (%)	Gap (pp)
Ages 19-64 (legacy)	50	34	AK, ME, MT, ND, NH, SD, VT, WV, WY	Uninsured	22.8	46.0	-23.1
Ages 19-64 (legacy)	50	34	AK, ME, MT, ND, NH, SD, VT, WV, WY	Medicaid	41.1	25.1	+16.0

Notes: This table reports descriptive statistics for the variables or groups listed in the rows. Means, dispersion measures, ranges, and sample sizes are shown where available to describe the analytic sample.

A4. Leave-One-Donor-Out (Top 6) - Primary 26-54 Stratum

Leave-One-Donor-Out (Top 6 by Weight) - PRIMARY 26-54 Stratum

Drops each top-weight donor and reruns ASCM on the ages 26-54, 1-200% FPL panel.

Outcome	Dropped donor	Donor weight (%)	Baseline gap (pp)	LOO gap (pp)	Change (pp)
Uninsured	DE	11.9	-25.4	-23.3	+2.1
Uninsured	RI	10.2	-25.4	-25.5	-0.1
Uninsured	AR	6.9	-25.4	-25.3	+0.1
Uninsured	WY	6.7	-25.4	-27.1	-1.7
Uninsured	WI	5.6	-25.4	-25.6	-0.2
Uninsured	MI	5.4	-25.4	-25.8	-0.4
Medicaid	DE	20.2	+19.3	+17.7	-1.6
Medicaid	NM	14.4	+19.3	+19.8	+0.5
Medicaid	MA	12.5	+19.3	+19.6	+0.4
Medicaid	RI	12.4	+19.3	+19.3	+0.0
Medicaid	SD	12.0	+19.3	+19.2	-0.1
Medicaid	CT	7.2	+19.3	+19.1	-0.2

Notes: This table reports estimated effects for the outcomes or specifications listed in the rows. Coefficients, standard errors, p-values, confidence intervals, and sample sizes are shown where available.

A5. Donor-Policy Audit

Donor-Policy Audit - Oregon Healthier Oregon

Updated on 2026-04-27.

Decision Rule

The primary donor pool excludes states with adult immigrant-coverage policies that could directly affect the low-income noncitizen adult target cell during or near the ACS 2018-2024 window. The audited sensitivity pool follows the KFF March 2024 adult-coverage list and re-includes Minnesota because its adult MinnesotaCare expansion begins after the 2024 ACS post year. Child-only and pregnancy-only immigrant coverage policies are documented but are not treated as adult target-cell contamination.

Minnesota is excluded in the conservative primary pool because of near-window policy change, but the audited sensitivity pool re-includes it because the adult expansion begins in 2025.

Audit Table

State	State name	Primary role	Adult-policy audit	Source
CA	California	Excluded from primary donor pool	Adult coverage regardless of immigration status phased in 2020, 2022, and 2024.	KFF 2025; California DHCS
CO	Colorado	Excluded from primary donor pool	State-funded OmniSalud/marketplace subsidies for adults regardless of immigration status.	KFF 2024; KFF 2025
DC	District of Columbia	Excluded from primary donor pool	Longstanding locally funded Healthcare Alliance coverage for low-income adults.	KFF 2024; KFF 2025
IL	Illinois	Excluded from primary donor pool	State-funded adult immigrant coverage for older adults and ages 42-64 during the window.	KFF 2024; KFF 2025
NY	New York	Excluded from primary donor pool	State-funded coverage for adults ages 65 and older regardless of immigration status beginning in 2023.	KFF 2025; NILC 2026
OR	Oregon	Treated state	Healthier Oregon extended full OHP benefits regardless of immigration status to all income-eligible adults in July 2023.	KFF 2025; Oregon OHA
WA	Washington	Excluded from primary donor pool	Marketplace subsidies and July 2024 Apple Health Expansion create adult coverage-policy overlap.	KFF 2024; KFF 2025
MN	Minnesota	Excluded from primary donor pool	Adult MinnesotaCare expansion begins in January 2025, after the ACS 2018-2024 analysis window.	KFF 2025; Minnesota DHS
CT	Connecticut	Retained if otherwise supported	Children/pregnancy-focused state-funded coverage; no broad adult coverage in the analysis window.	KFF 2024; NILC 2026

State	State name	Primary role	Adult-policy audit	Source
ME	Maine	Retained if otherwise supported	Children/pregnancy-focused state-funded coverage; no broad adult coverage in the analysis window.	KFF 2024; NILC 2026
MA	Massachusetts	Retained if otherwise supported	Children/pregnancy-focused state-funded coverage; no broad adult coverage in the analysis window.	KFF 2024; NILC 2026
NJ	New Jersey	Retained if otherwise supported	Children/pregnancy-focused state-funded coverage; no broad adult coverage in the analysis window.	KFF 2024; NILC 2026
RI	Rhode Island	Retained if otherwise supported	Children/pregnancy-focused state-funded coverage; no broad adult coverage in the analysis window.	KFF 2024; NILC 2026
UT	Utah	Retained if otherwise supported	Children-focused state-funded coverage; no broad adult coverage in the analysis window.	KFF 2024; NILC 2026
VT	Vermont	Retained if otherwise supported	Children/pregnancy-focused state-funded coverage; no broad adult coverage in the analysis window.	KFF 2024; NILC 2026

Notes: This table documents the source files, scripts, variables, or data inputs used in the analysis. It is included to make the construction of the analytic evidence reproducible.

Sources

- KFF. More States Are Providing Fully State-Funded Health Coverage to Some Individuals Regardless of Immigration Status. May 1, 2024.
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- National Immigration Law Center. Medical Assistance Programs for Immigrants in Various States. March 30, 2026.
- Oregon Health Authority. Healthier Oregon. https://www.oregon.gov/oha/OHP/pages/healthier-oregon.aspx