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Impact of Medicaid Pregnancy Dental Benefits on Prenatal Dental Utilization and Birth Outcomes*

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Abstract

Despite elevated risks for oral health problems, more than half of pregnant women do not visit the dentist at least once during pregnancy. The Medicaid program covers more than 40% of US births and represents an important source of dental coverage with benefits that vary at the state level. We examine the effects of state-level pregnancy dental benefits using a difference-in-differences strategy and data from the 2012-2019 Pregnancy Risk Assessment and Monitoring System (PRAMS). We find that providing dental coverage to pregnant Medicaid recipients increases dental cleaning rates by 7.16 percentage points, or 29% relative to baseline. We also examine linked birth certificate data given evidence that poor oral health during pregnancy is associated with adverse pregnancy and birth outcomes. We find suggestive evidence of reductions in small for gestational age, preterm birth, and very low birthweight, though only the estimates for small for gestational age and very low birthweight are statistically significant at conventional levels. These findings underscore the importance of expanding access to preventive dental care during pregnancy as a strategy for improving long-term population health.

JEL Codes: I13, I14, I18, J13

Keywords: Medicaid, Dental care, Pregnant women, Birth outcomes

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1 Introduction

Poor oral health during pregnancy may have long term implications for the oral and overall health of expectant mothers and their children (Dye et al., 2011; Chaffee et al., 2014; Iheozor-Ejiofor et al.; Ide & Papapanou, 2013; Nasseh et al., 2017; Jeffcoat et al., 2014). Oral health problems can cause pain that interferes with eating, speaking, and overall quality of life (CDC, 2024a; Naito et al., 2006). Moreover, poor oral health has been linked to systemic health conditions including cardiovascular disease (Sanz et al., 2020; Oliveira et al., 2010), diabetes (Nasseh et al., 2017; Chee et al., 2013; Díaz-Romero et al., 2005), respiratory conditions (Manger et al., 2017), and adverse pregnancy and birth outcomes (Jeffcoat et al., 2014; Puertas et al., 2018). Despite elevated risks for oral health problems during pregnancy and the availability of effective interventions to address these issues, more than half of pregnant people do not visit the dentist at least once during pregnancy (Kranz & Estrada-Darley, 2022; Lee et al., 2022b), including more than one-third who report experiencing dental problems (Lee et al., 2022b).

Medicaid finances more than 40% of US births and therefore represents an important lever for improving maternal and infant health outcomes (KFF, 2023). States have flexibility in how they structure their programs, including whether or not to offer optional benefits including dental, vision, and hearing healthcare services, among others. While all states cover emergency dental services during pregnancy to relieve pain and infection (e.g., tooth extractions), Medicaid coverage of preventive and restorative dental services vary at the state level.

In this paper, we examine the effects of Medicaid pregnancy dental benefits using 2012-2019 data from the Pregnancy Risk Assessment Monitoring System (PRAMS). Our main analysis uses a stacked difference-in-differences approach to account for variation in policy timing and an enhanced dataset compiled via direct state data release requests. Our primary outcome is reported receipt of a dental cleaning during pregnancy. Given evidence that poor oral health is associated with adverse pregnancy and birth outcomes, we also use linked birth certificate data to examine preterm birth, small for gestational age (10th percentile), low birthweight (under 2500 grams), and very low birthweight (under 1500 grams).

We find that exposure to Medicaid dental benefits during pregnancy significantly increases dental cleaning rates by 7.16 percentage points, representing a 29.1% increase relative to the baseline rate (24.6%). Event study analyses generally do not indicate a violation of the parallel trends assumption and also suggest that positive impacts persist over time. We also control for Medicaid dental benefits for non-pregnant adults during the year before conception in a sensitivity analysis and our findings hold. In subgroup analyses, point estimates are larger among non-Hispanic Black compared to non-Hispanic white women, women with lower compared to higher pre-pregnancy risk factors, urban

compared to rural residents, and women ages 26-34 compared to 21-25 or 35 and older. However, only the difference for ages 21-25 compared with 26-34 is statistically significant.

In our analysis of birth outcomes, we find suggestive evidence of reductions in small for gestational age, preterm birth, and very low birthweight. We estimate that Medicaid pregnancy dental benefits reduce small for gestational age by 1.19 percentage points (10% reduction), preterm birth by 0.90 percentage points (8% reduction), and very low birthweight by 0.47 percentage points (28% reduction). However, only the estimates for small for gestational age and very low birthweight are statistically significant at conventional levels. We also estimate a relatively modest increase in low birthweight (0.50 percentage points or a 5% increase) that is not statistically significant. Overall, these findings are suggestive that policy-induced increases in dental care use may improve infant health.

While a substantial literature has examined the effects of Medicaid dental benefits for non-pregnant adults on dental care utilization and health outcomes (Decker & Lipton, 2015; Singhal et al., 2017; Meyerhoefer et al., 2019), comparatively fewer studies have focused specifically on pregnancy-related dental benefits. One notable quasi-experimental study from Virginia found increases in dental cleanings following implementation of comprehensive Medicaid pregnancy dental benefits (Naavaal & Harless, 2022); however, no prior research has examined impacts on birth outcomes. Our study addresses this gap by examining multi-state variation in pregnancy dental benefit policies and linking these policies not only to dental care use but also to important birth outcomes. In doing so, we contribute to broader literatures examining optional Medicaid benefits (Buchmueller et al., 2016; Abdus & Decker, 2019; Wehby et al., 2019), Medicaid coverage during pregnancy (**??**), and the longer-term intergenerational effects of maternal health interventions.

Overall, our findings provide evidence that pregnancy dental benefits induce meaningful increases in dental care use among a population with a high prevalence of oral health problems and a low rate of dental visits relative to other, non-pregnant adults. We also find suggestive evidence that dental benefits may improve birth outcomes, particularly small for gestational age and very low birthweight. While we did not find a significant reduction in disparities by race and ethnicity among Medicaid-enrolled pregnant women, these policies are likely to improve equity in dental care access given disproportionate Medicaid enrollment among adults with lower incomes and communities of color.

Beyond immediate healthcare utilization, our study also contributes to a broader discussion on the long-term benefits of preventive maternal health policies. Improved prenatal healthcare access not only enhances maternal well-being but also has lasting intergenerational effects on newborn health, potentially influencing early-life development

and future socioeconomic trajectories (East et al., 2023; Aizer & Currie, 2014; Brown et al., 2020; Liu et al., 2017). As policymakers consider future expansions or modifications to Medicaid, these findings provide actionable insights on how tailoring benefits to meet the needs of high-risk populations can yield meaningful improvements for current enrollees and future generations.

2 Background and Mechanisms

2.1 Pregnancy and Oral Health

In a national consensus statement, the Oral Health Care During Pregnancy Expert Workgroup recommended that pregnant people receive prenatal dental care, but pregnant people are less likely to visit the dentist (44%) than reproductive-age people who are not pregnant (65%).Moreover, significant disparities exist: non-Hispanic Black women had about 14% lower odds of receiving a dental cleaning during pregnancy compared to non-Hispanic White women, and Medicaid-enrolled pregnant people had roughly half the odds of dental visits compared to those with private insurance (Lee et al., 2022b).

Oral health problems are common among pregnant people with up to three-quarters affected by gum disease (CDC, 2024b). Hormone fluctuations during pregnancy increase the risk of developing gingivitis, a mild form of gum disease (Figuero et al., 2013; CDC, 2024b). If left untreated, gingivitis can progress to periodontitis, causing damage to the gums and bone that may lead to tooth loss. Pregnant people are also more susceptible to tooth decay given changes in eating and oral hygiene habits (e.g., reduced tooth brushing and flossing) (Boggess et al., 2010; Hunter & Yount, 2011). Poor oral hygiene and the presence of gum disease during early pregnancy are highly predictive of gum disease in later pregnancy (Gil-Montoya et al., 2023). Moreover, intervention studies suggest nonsurgical periodontal therapy is highly effective in resolving symptoms among pregnant people (Bobetsis et al., 2020; Kaur et al., 2014).

Recent U.S.-based observational studies have provided mixed evidence regarding the association between oral health during pregnancy and infant health outcomes such as preterm birth and low birth weight. For example, observational data suggest that maternal periodontal disease may modestly increase risks of adverse neonatal outcomes; pregnant people receiving dental cleanings have shown slightly lower odds of preterm delivery (Lee et al., 2025). However, the evidence remains correlational, and causation has not been firmly established due to confounding socioeconomic and behavioral factors.

Randomized controlled trials and systematic reviews have generally found inconclusive evidence regarding the benefits of periodontal treatment during pregnancy for improving birth outcomes. A Cochrane systematic review concluded there was no clear evidence that treating periodontal disease during pregnancy significantly reduces preterm birth

rates, although slight reductions in low-birth-weight infants were noted (Iheozor-Ejiofor et al., 2017). More recent reviews similarly report no statistically significant associations, emphasizing the need for further robust research to clarify these relationships (Montoya-Carralero et al., 2024). Thus, current evidence supports routine dental care for maternal well-being, but its impact on infant outcomes remains uncertain.

2.2 Medicaid Dental Benefits

Medicaid plays a vital role in providing health coverage to low-income populations in the United States, covering over 40% of all births nationwide (KFF, 2023). However, unlike mandatory benefits such as hospital or prenatal care, adult dental services are considered optional under federal Medicaid law. As a result, states have broad discretion in determining whether and how to offer dental coverage to adult enrollees, including pregnant people. While most states cover emergency-only dental services to address acute pain or infection, fewer provide comprehensive preventive and restorative dental care. This considerable variation across states and over time creates an opportunity to assess how the availability of Medicaid dental benefits affects service utilization among pregnant people—a population with elevated oral health risks but persistently low rates of dental care use.

Several recent studies suggest that dental insurance is associated with dental care utilization among pregnant people, although this research is generally cross-sectional (Robison et al., 2021; Lee et al., 2022a), based on self-report data (Naavaal & Harless, 2022; Robison et al., 2021; Lee et al., 2022a), and/or focuses on a single state (Naavaal & Harless, 2022). The only quasi-experimental study we are aware of examined Virginia's 2015 addition of a comprehensive Medicaid pregnancy dental benefit and found that reports of receiving a dental cleaning increased among Medicaid-enrolled pregnant people relative to privately insured pregnant people before and after the policy's implementation (Naavaal & Harless, 2022). A second recent cross-sectional study found that Medicaid-enrolled pregnant people with no Medicaid dental coverage (27%) were less likely to have a dental cleaning during pregnancy when compared to those with limited benefits (e.g., fewer than 100 services or an annual spending cap of less than $1,000) (37%) and extensive benefits (e.g., at least 100 services and an annual spending cap of at least $1,000) (45%) (Lee et al., 2022a). Across different population groups, Medicaid eligibility expansions to pregnant people and infants during their first year of life were associated with a significant reduction in permanent tooth loss on reaching young adulthood for non-Hispanic Black cohorts (Lipton et al., 2016). While this research could not disentangle the specific mechanisms for these effects, the importance of eligibility expansions targeting pregnant people and infants is suggestive of a critical role for Medicaid pregnancy benefits. These findings also provide support for the notion of longer

run oral health improvements following early life interventions.

While evidence on the impacts of Medicaid pregnancy dental benefits remains somewhat limited, there is a robust body of research on dental benefits for non-pregnant adults and their effects on dental care use and oral health (Choi, 2011; Decker & Lipton, 2015; Singhal et al., 2015, 2017; Abdus & Decker, 2019; Meyerhoefer et al., 2019; Wehby et al., 2019; Lyu et al., 2020; Singhal et al., 2021; Wehby et al., 2022; Lyu & Wehby, 2023) . Decker & Lipton (2015) found that when states provided adult dental benefits beyond emergency care, past-year dental visits increased by about 13 percentage points and exam-based measures of untreated caries declined by about 9 percentage points. The increase in dental visits represented a 34% increase relative to the average rate in states without dental benefits (38%). Meyerhoefer et al. (2019) also found that Medicaid dental benefits increased basic and major services use by 23% and 36%, respectively. Other researchers have found that Medicaid dental benefits reduce out-of-pocket spending on dental care (Abdus & Decker, 2019), reduce emergency department visits for oral conditionsSinghal et al. (2015), and that they induce a supply-side response with dentists increasing their acceptance of Medicaid patients (Buchmueller et al., 2016).

2.3 Mechanisms

The primary mechanism for an impact of Medicaid pregnancy dental benefits on dental visits is via a reduction in out-of-pocket costs for pregnant enrollees. According to surveys of dental practitioners, the average cost of a dental cleaning ranges from $90 to $120 and fillings from $100 to $1200 per tooth. In states that provide Medicaid dental benefits, enrollee cost-sharing amounts are typically small, ranging from $1 to $3, representing a substantial reduction in enrollee costs for dental services. Estimates suggest that providing Medicaid dental benefits to non-pregnant adults results in a reduction in annual out-of-pocket costs of $18.88 on average and $179.28 among those with a dental visit (Abdus & Decker, 2019). While not consistently available in PRAMS, our analysis will examine the association between pregnancy dental benefits and unmet needs for dental care due to cost to assess the likely contribution of cost reductions to our findings (results not yet available).

Moreover, changes in Medicaid pregnancy dental benefits may bring salience to the importance of oral health during pregnancy through news coverage and notifications to beneficiaries, further increasing demand for services. We investigate attention to dental visits and oral health around the time of policy implementation using google trends. Searches for "dentist" and "dental" generally increase in treatment states around the time that dental benefits are added, though we observe little pattern in searches for "low birthweight", "preterm birth" or "gestation" either alone or in combination with dental health search terms. (Results not yet available.)

Providing Medicaid dental benefits could also have supply side impacts. According to mixed economy model with private and public payers (Sloan et al., 1978), dentists would increase acceptance of Medicaid patients but reduce the quantity of services supplied in response to Medicaid dental benefits. The latter prediction is based on lower payment rates to dentists in Medicaid relative to private plans. Research examining dentist responses to Medicaid dental coverage expansions found increased employment of dental hygienists to accommodate additional demand resulting in minimal disruption to provided services.

In terms of impacts on birth outcomes, there are several possible pathways. First, poor oral health during pregnancy may increase inflammation, worsening systemic health and negatively affecting the fetal environment. Furthermore, periodontal pathogens have been identified in the placenta and amniotic fluid, allowing for the possibility of direct impacts of maternal oral infection on infant health. While rigorous studies supporting links to birth outcomes are limited, retrospective cohort studies using linked medical and dental claims suggest that treatment for periodontal disease at baseline precedes lower total medical spending for atypical pregnancy care. Further, evidence from randomized controlled trials, while mixed, provides some evidence that periodontal intervention during pregnancy may reduce preterm birth and low birthweight. While we are limited in our ability to examine this pathway in the PRAMS, recent research suggests that dental benefits for non-pregnant adults are associated with improvements in general reported health status. We also confirm this finding among reproductive-aged women using data from the Behavioral Risk Factor Surveillance System (results available on request).

In addition to possible impacts on maternal systemic health and the fetal environment, pregnancy dental benefits could have indirect impacts on infant health by inducing changes to maternal health behaviors. Other types of prenatal care use could increase if dentists counsel pregnant patients on current guidelines for obstetric visits. Conversely, dental visits may crowd out other prenatal care use given time and work constraints. We examine the effects of pregnancy dental benefits on the Kotelchuk index, a measure of prenatal care adequacy, and find no evidence of an effect. Pregnancy dental benefits could also affect other types of health behaviors if dentists counsel pregnant women on dietary or smoking habits, via an income effect, or moral hazard. Given the adverse consequences of smoking during pregnancy, we assess whether pregnancy dental visits affect smoking prevalence and also find no evidence of an impact.

3 Data

The data for this study is drawn from the Pregnancy Risk Assessment Monitoring System (PRAMS), a state-based surveillance system managed by the Centers for Disease

Control and Prevention (CDC) in collaboration with state health departments. PRAMS collects comprehensive, population-based data on maternal experiences before, during, and shortly after pregnancy, with an emphasis on maternal health behaviors and access to care. The survey samples a state-representative subset of women who have recently given birth, sampling between 1,000 and 3,000 individuals annually from each participating site (typically a state). The dataset includes self-reported measures of dental care access during pregnancy and linked birth certificate information on birth outcomes.

PRAMS data availability varies by year and state, as the CDC only releases data for a given state-year if the site meets a minimum weighted response rate threshold (typically 60%). Additionally, even when a state meets the threshold, its data may not be publicly released unless the site opts to make it available. To ensure more complete coverage, we submitted site-specific data requests to obtain restricted-use PRAMS data for states not included in the standard release files. As a result, our dataset includes restricted-use data from Colorado, Tennessee, South Carolina, Mississippi, and Virginia. These additional data enhance the scope and representativeness of our analysis.

Our analysis uses PRAMS data from 2012 to 2019. We begin our analysis in 2012 because this is the first year when the question about dental cleanings during pregnancy is included in the survey. Previous surveys include questions about dental care use before pregnancy in addition to other questions related to dental care access, but only the question about dental cleanings is consistently available over time during recent years. We end our analysis in 2019 to avoid confounding due to the COVID-19 pandemic given evidence of depressed healthcare utilization, interruptions to prenatal care, and infant health impacts. However we include data through 2021 in a sensitivity analysis.

We focus on individuals aged 21 and older who were enrolled in Medicaid during pregnancy. This restriction allows us to target populations most likely to be affected by Medicaid dental policy changes since all Medicaid enrollees up to age 20 receive dental coverage under the Early and Periodic, Screening, Diagnostic, and Treatment benefit. We have access to information on the month and year of birth, allowing us to estimate the timing of conception. We match these dates with the month and year of policy implementation to define our primary policy indicator, which is equal to one if the respondent had any exposure to pregnancy dental benefits and zero otherwise.

Our primary outcome for dental care utilization is an indicator of having received a dental cleaning at any time during the most recent pregnancy. Furthermore, we investigate four main birth outcomes, including small for gestational age (at 10^{th} percentile), preterm birth, low birth weight, and very low birth weight. The PRAMS also provides a rich set of individual and socioeconomic characteristics at the individual level, allowing us to control for potential factors that may influence dental care access and utilization. We supplement the PRAMS data with a comprehensive set of

state-by-year-specific variables to account for potential confounding factors related to state-level socioeconomic and policy changes.

(Table 2 here)

Table 2 provides descriptive statistics offering a snapshot of the study population. In total, we obtain 71,442 individual observations. Regarding dental care utilization, 44% of respondents reported receiving a dental cleaning during pregnancy. For birth outcomes, approximately 10% of births are classified as low birth weight, 11% as preterm, and 11% as small for gestational age (10th percentile). The demographics of the sample reveal that the average maternal age is 28 years, with 56% of respondents having less than a college education. The sample is racially and ethnically diverse, with 42% identifying as non-Hispanic White, 30% as non-Hispanic Black, and 22% as Hispanic. Additionally, 40% of respondents are married, and 80% reside in urban areas.

4 Empirical Strategy

4.1 Stacked Difference-in-differences Approach

This study employs a stacked difference-in-differences (DiD) design, following recent methodological guidance from Wing et al. (2024). In this approach, we define a series of "sub-experiments," each centered around a unique policy adoption date. For each sub-experiment, the treatment group comprises states implementing pregnancy dental benefits at that date, and the control group consists of states that did not adopt similar benefits within the event window. This design decomposes staggered adoption into a set of two-by-two DiD comparisons, mitigating the bias that can arise in two-way fixed effects models with heterogeneous treatment timing. We adopt this approach for several reasons articulated in Wing et al. First, our setting includes a moderate number of treated and control states, which facilitates clean sub-experiment construction. Second, policy adoption is monotonic—states added but did not remove dental benefits during the study period—making treatment assignment consistent over time. Third, our data are repeated cross-sections from PRAMS, and the stacked DiD approach naturally accommodates survey weights and does not require panel tracking of individuals. Taken together, these features make stacked DiD an appropriate and robust choice for our empirical setting.

As Figure 1 shows, five PRAMS states including Colorado, Illinois, South Carolina, Utah, and Virginia began offering pregnancy dental benefits during the study period (shown in green). Twenty-six PRAMS states maintained pre-existing benefits (shown in blue) and nine states did not offer pregnancy dental benefits throughout our entire study period (shown in red). Two states that had not adopted pregnancy dental benefits by 2019 did so after 2019 (West Virginia and Delaware). States shown in gray did not consistently

contribute to the PRAMS during our period of analysis and are therefore excluded. We also exclude the 26 states with pre-existing dental benefits to avoid confounding arising from continually evolving trends in these "already treated" units, consistent with best practices in stacked DiD designs Wing et al. (2024).

Table 1 summarizes the states included in each sub-experiment used in our primary analysis. For example, Utah's policy adoption in October 2013 forms one sub-experiment, with the nine states that did not offer pregnancy dental benefits during the study period serving as controls. Each sub-experiment uses symmetric event windows of approximately 4 to 6 years, depending on the implementation date and data availability. Since 2012 was the first year the dental cleaning question was asked, some sub-experiments have shorter pre-implementation windows relative to post-implementation windows. For example, Utah's event window includes January 2012 through October 2016.

(Figure 1 here)

(Table 1 here)

4.2 Estimation

We estimate aggregated average treatment effects (ATEs) and event study models that include the leads and lags of the policy adoption date. To generate ATEs we estimate the following model:

$$Y_{istd} = \mu_{sd} + \omega_1 \text{PregDental}_{istd} + \mathbf{X}_{istd}\boldsymbol{\beta} + \lambda_t + \epsilon_{istd} \tag{1}$$

Where Y_{istd} denotes the outcome of interest for individual i (e.g., dental cleaning utilization or birth outcome) in state s, time t, and sub-experiment d. PregDental_{istd} is a binary indicator equal to one if a respondent is imputed to have any exposure to pregnancy dental benefits during their pregnancy and zero otherwise. $\mathbf{X}_{istd}$ is a vector of individual- and state-level control variables. Individual-level controls include income, maternal and paternal education, age, race, ethnicity, marital status, urban versus rural residence, and birth order. State-by-year controls capture state-level socioeconomic conditions, COVID-19 policy context, and healthcare infrastructure, including fertility rate, Medicaid managed care enrollment, federally qualified health centers per capita, state unemployment rate, business closures, COVID-19 case and death rates, stay-at-home orders during pregnancy, elective procedure restrictions, public health guidance for pregnant individuals, Affordable Care Act implementation, and number of dentists per capita.

The specification includes state-by-sub-experiment fixed effects (μ_{sd}) to control for time-invariant differences within each policy comparison group and quarter-by-year fixed

effects (λ_t) to account for national shocks over time. Standard errors are clustered at the state level.

To estimate the overall treatment effect, we run separate two-by-two DiD models within each sub-experiment—defined by a distinct policy adoption date—and compare outcomes before and after adoption in treated states to changes in control states during the same period. These sub-experiment estimates are then aggregated using stacked weights, which give greater influence to comparisons with larger sample sizes. We also apply PRAMS survey weights at the individual level to ensure population representativeness. This combined weighting strategy allows for efficient and unbiased estimation across staggered adoption settings.

Our event study model is specified as follows:

$$Y_{istd} = \mu_{sd} + \sum_{\tau=-\kappa_a}^{-2} \alpha_\tau \cdot 1(TSE_{td} = \tau) + \sum_{\sigma=0}^{\kappa_b} \delta_\sigma \cdot 1(TSE_{td} = \sigma) + \mathbf{X}_{istd}\boldsymbol{\beta} + \lambda_t + \epsilon_{istd} \quad (2)$$

Where the variable TSE_{td} represents the number of months since policy implementation, with α_τ and δ_σ capturing pre-policy and post-policy event-time effects, respectively. All other variables are as defined before. Our event study specification aligns birth year and month with the timing of Medicaid dental benefit implementation and groups the pre- and post-treatment periods into three-month intervals. We include 8 pre- and post-policy implementation indicators (i.e., including up to 22 months or more both preceding and following policy changes). This structure allows for a detailed examination of how outcomes evolve over time. The model differentiates between partial policy exposure, observed in the initial post-policy intervals, and full policy exposure, captured in later periods. Given typical gestation lengths, δ_4 and subsequent post-policy indicators capture full policy exposure, with exposure increasing across indicators δ_1 to δ_3. By aligning events temporally, this approach provides a clearer understanding of the timing, stabilization, and persistence of policy impacts, offering insights into both short-term effects and longer-term trends.

Equation (2) tests the plausibility of the parallel trends assumption, which is critical to a causal interpretation of our estimates. Significant coefficient estimates for the pre-period(α_τ), or estimates that exhibit an apparent increasing or decreasing trend, would cast doubt on causality. The post-policy coefficients δ_σ capture the dynamic effects of the policy, and in our context, whether impacts differ according to partial vs. full exposure during pregnancy.

In addition to the event study model, we conduct several sensitivity and robustness checks to assess the stability of our results. First, we control for dental benefits available to non-pregnant adults in the year prior to conception to account for potential confounding

from broader adult dental coverage expansions. Second, we estimate stratified models by income and education level to assess whether the effects of pregnancy dental benefits differ across socioeconomic groups. Third, we re-estimate our models excluding low-income individuals to ensure that observed effects are not driven by those most likely to benefit from Medicaid. Fourth, we test the sensitivity of our findings to the inclusion of observations from the post-COVID-19 period to assess whether pandemic-related disruptions bias our estimates. Fifth, we extend the analysis to include all insurance types in an intent-to-treat framework to evaluate whether our results hold under broader population definitions. Sixth, we conduct a falsification test by estimating policy effects among privately insured individuals who were not eligible for the benefit. Finally, we perform a series of leave-one-out analyses, sequentially excluding each treated state to ensure that no single sub-experiment drives the results. These checks support the robustness of our findings and strengthen confidence in the causal interpretation of our estimates.

5 Results

This section presents the findings on the impact of Medicaid pregnancy dental benefits on dental care utilization and birth outcomes. The analysis evaluates how these benefits influence the likelihood of receiving prenatal dental cleaning and their subsequent effects on key birth outcomes, including small for gestational age (at 10^{th} percentile), preterm birth, low birth weight, and very low birth weight. Additionally, event study models are employed to examine the dynamic treatment effects over time and test the parallel trends assumption. Heterogeneous treatment effects are explored across demographic and socioeconomic subgroups, shedding light on disparities in policy impacts and highlighting potential areas for targeted interventions.

5.1 Effects of Medicaid Pregnancy Dental Benefits on Dental Cleanings

We estimate that Medicaid dental benefits for pregnant women increase the probability of having received a dental cleaning during pregnancy by 7.16 percentage points(Table 3, Column (1). Given the baseline mean of 24.6% in states without pregnancy dental benefits, this estimate represents a 29.1% relative increase. Results for dental cleanings are similar across specifications with and without individual and state-by-year controls, ranging from 6.58 (26.7% increase) to 8.06 (32.8% increase) percentage points (Appendix Table A.1).

(Table 3 here)

Figure 2 provides event study estimates of the impact of Medicaid pregnancy dental benefits on prenatal dental cleaning rates. The temporal dynamics suggest that while there is no pre-existing trend in prenatal dental cleaning rates before policy implementation, the effect of Medicaid pregnancy dental benefits gradually intensifies in the months afterwards, with significant increases becoming evident between 7 and 9 months post-adoption. This upward trajectory suggests that the early post-policy period represents a phase of partial policy exposure, during which the full impact of expanded benefits may not be immediately realized. As time progresses, the observed effect grows stronger, reflecting full policy exposure and a sustained improvement in dental care utilization. By the later post-policy months, the effect plateaus at a consistently higher rate of dental cleaning compared to pre-policy levels, indicating a lasting shift in healthcare-seeking behavior among Medicaid-enrolled pregnant individuals.

(Figure 2 here)

We also analyze differences across demographic subgroups and find broadly consistent increases in dental care utilization in response to Medicaid pregnancy dental benefit expansions (Figure 4). Non-Hispanic Black and non-Hispanic White individuals experienced statistically significant increases in prenatal dental cleaning rates. While Hispanic individuals also exhibited positive point estimates, the effects for this group are statistically imprecise. These findings suggest that the Medicaid expansions may have contributed to narrowing disparities in access to preventive dental care across racial and ethnic groups, although further research is needed to confirm the impact among Hispanic populations due to the lack of statistical precision.

(Figure 4 here)

Geographic differences also emerged, with rural residents showing not significant increase in utilizing prenatal dental cleaning compared to their urban counterparts. This pattern might reflect ongoing disparities in healthcare access between rural and urban areas, possibly driven by factors such as limited availability of dental providers or the increased travel distance required to access care in rural settings. Age-specific effects reveal that individuals aged 26 to 34 experienced the largest improvements in dental cleaning utilization among all age groups, suggesting that this segment of the population may have been particularly well-positioned to benefit from the policy. Furthermore, individuals without pre-pregnancy health risks exhibited stronger effects, indicating that those without underlying health conditions might respond more favorably to the expansion of dental benefits. These variations highlight the differential impacts of Medicaid expansions across population subgroups, with distinct responses based on demographic, geographic, and health-related factors.

5.2 Effects of Medicaid Pregnancy Dental Benefits on Birth Outcomes

We estimate the effects of prenatal exposure to Medicaid dental benefits on four primary birth outcomes: small for gestational age (SGA) at the 10th percentile, preterm birth, low birth weight, and very low birth weight. Table 3 presents these findings in Columns (2) to (5). Notably, Medicaid dental benefits significantly reduce the likelihood of a newborn being small for gestational age by 1.19 percentage points, representing a 9.52% decrease relative to the baseline mean of 12.5%. Additionally, we observe a statistically significant reduction in very low birth weight by 0.47 percentage points. However, the estimated impacts on preterm birth (-0.99 percentage points) and low birth weight are not statistically significant.

Figure 3 illustrates event study plots for each birth outcome. Before policy implementation, estimates for most outcomes largely hover near zero with overlapping confidence intervals, suggesting parallel trends between treated and control states. However, the estimates for low birth weight deviate from zero prior to policy adoption, indicating potential violations of the parallel trends assumption for this outcome. Post-policy implementation, we consistently observe negative effects for small for gestational age, preterm birth, and very low birth weight. These effects are especially pronounced for small for gestational age and very low birth weight. While the table estimates for preterm birth are imprecise, the event study plots reveal consistent post-policy reductions, suggesting a potential impact not captured in the average effect estimates. In contrast, there is no consistent evidence of impact on low birth weight.

(Figure 3 here)

We assess potential heterogeneity in the effects of Medicaid pregnancy dental benefit expansions on birth outcomes across geographic, racial, and age subgroups. These estimates are somewhat noisy, particularly for lower-prevalence outcomes, and we do not find statistically significant differences across subgroups—an expected result given the limited evidence of subgroup differences in dental cleaning impacts (Figure A.3).

5.3 Robustness Checks and Mechanisms

To ensure the validity and robustness of our main findings and to better understand the underlying mechanisms driving observed effects, we conduct additional analyses through a series of robustness checks and mechanism explorations. Table 4 presents estimates examining the effects of Medicaid pregnancy dental benefits across different education and income groups. These analyses are conducted on the full sample, which includes individuals with Medicaid, private insurance, and other forms of coverage. The purpose

of this stratification is to assess whether the policy's impact varies by socioeconomic status and to identify which subgroups benefit the most from the expansion of dental benefits.

Results show consistent and statistically significant improvements in prenatal dental cleaning rates across all subgroups, with the strongest effects observed among individuals with lower education and those with incomes less than $25,000 and $50,000. These patterns suggest that the policy may be particularly effective in expanding access to dental care among historically underserved populations. In terms of birth outcomes, the overall estimates are generally imprecise. However, we find a statistically significant reduction in low birth weight among the low-education subgroup, indicating a potential health benefit of the dental policy among individuals facing greater structural barriers to care. These findings reinforce the importance of Medicaid dental expansions in improving preventive care access, particularly for socially and economically disadvantaged groups.

(Table 4 here)

Table 5 further examines the joint effects of Medicaid pregnancy dental benefits and broader adult Medicaid dental expansions on prenatal dental cleaning and birth outcomes. This analysis serves to isolate the specific contribution of pregnancy-targeted dental coverage relative to general Medicaid dental eligibility expansions for adults. The results confirm that improvements in prenatal dental cleaning and reductions in very low birth weight are consistent even when controlling for non-pregnancy adult Medicaid expansions. In contrast, the estimated effects for other birth outcomes are sensitive to the inclusion of adult expansions. Notably, adult (non-pregnancy) Medicaid expansions are associated with modest improvements—statistically significant at the 10% level—for small-for-gestational-age births and low birth weight. These findings underscore the unique value of pregnancy-specific dental coverage in driving improvements in maternal oral health, while also suggesting that broader Medicaid expansions may offer complementary, albeit limited, benefits for certain birth outcomes.

(Table 5 here)

Table 6 presents estimates of the effect of Medicaid pregnancy dental benefits on dental cleaning and birth outcomes after excluding individuals classified as low-income. This analysis is intended to test whether the observed effects persist among higher-income populations. The results indicate that even after excluding low-income individuals, Medicaid pregnancy dental benefits are associated with a statistically significant increase in prenatal dental cleaning (8.99 percentage points) and significant reductions in small-for-gestational-age births, low birth weight, and very low birth weight. The effect on preterm birth remains negative but is not statistically significant. These findings

suggest that while low-income populations may benefit most strongly from the policy, meaningful improvements are also observed among higher-income individuals, indicating broader relevance of the dental benefit expansion across income levels.

(Figure 6 here)

Table 6 presents estimates of the effect of Medicaid pregnancy dental benefits on dental cleaning and birth outcomes after excluding individuals classified as low-income. This analysis is intended to test whether the observed effects persist among higher-income populations. The results indicate that even after excluding low-income individuals, Medicaid pregnancy dental benefits are associated with a statistically significant increase in prenatal dental cleaning (8.99 percentage points) and significant reductions in small-for-gestational-age births, low birth weight, and very low birth weight. The effect on preterm birth remains negative but is not statistically significant. These findings suggest that while low-income populations may benefit most strongly from the policy, meaningful improvements are also observed among higher-income individuals, indicating broader relevance of the dental benefit expansion across income levels.

(Figure 7 here)

Table 7 explores potential mechanisms through which Medicaid pregnancy dental benefits may influence birth outcomes by examining prenatal care utilization and maternal smoking behaviors. The results indicate no statistically significant effects on receiving adequate prenatal care, as measured by the Kotelchuck Index, or on maternal smoking behaviors before, during, or after pregnancy. These findings suggest that the improvements in birth outcomes associated with dental benefit expansions are unlikely to be driven by changes in these particular behavioral mechanisms. Instead, the effects may operate through other pathways, such as direct improvements in maternal oral health or reduced systemic inflammation associated with periodontal treatment.

In summary, the robustness checks and supplemental analyses provide strong support for the main findings. The consistent improvements in prenatal dental cleaning across diverse subgroups, along with significant reductions in certain adverse birth outcomes, underscore the effectiveness of Medicaid pregnancy dental benefit expansions. While we find limited evidence for behavioral mechanisms such as prenatal care utilization or smoking cessation, the persistence of effects across income levels and policy combinations suggests that improved access to dental care itself plays a critical role in shaping maternal and neonatal health outcomes.

6 Discussion

This study provides compelling evidence on the effectiveness of Medicaid pregnancy dental benefits in increasing access to prenatal dental care and its varying impacts on birth outcomes. Our results indicate that expanding Medicaid dental coverage significantly increased the likelihood of pregnant individuals receiving preventive dental cleanings, with particularly strong improvements observed among non-Hispanic Black and Hispanic individuals, as well as among individuals aged 26–34. These findings are consistent with previous research showing the importance of insurance coverage in addressing unmet healthcare needs during pregnancy. However, the benefits of expanded coverage were not uniformly distributed, as rural residents experienced smaller gains in dental care utilization but larger relative improvements in birth outcomes, including significant reductions in low birth weight and preterm birth. This discrepancy underscores the complex relationship between healthcare access and birth outcomes, particularly for populations facing structural barriers to care.

The heterogeneous treatment effects reveal that while Medicaid expansions helped reduce some disparities, particularly those based on geographic location and income, challenges remain in addressing disparities related to race and ethnicity. The lack of significant and consistent improvements in preterm birth and very low birth weight outcomes highlights the multifaceted nature of these outcomes, which are influenced by a range of factors beyond oral healthcare access. The findings suggest that Medicaid dental benefits alone are insufficient to comprehensively improve birth outcomes across all populations, emphasizing the need for a more holistic approach that considers social, medical, and environmental factors affecting maternal and child health.

The robustness of our results is supported by placebo tests, which show no significant changes in birth outcomes or dental cleaning rates among privately insured individuals who were not eligible for Medicaid pregnancy dental benefits. Additionally, we found no policy-related effects on unrelated health conditions, such as pre-pregnancy diabetes and hypertension, further confirming that the observed effects are specific to Medicaid recipients and not driven by external confounding factors. These findings strengthen the causal interpretation of our results, highlighting the role of Medicaid coverage expansions in improving maternal healthcare utilization and, to some extent, birth outcomes.

The findings from this study carry important policy implications for improving maternal and child health outcomes. Expanding Medicaid dental benefits has proven to be an effective strategy for increasing access to dental care among low-income pregnant individuals, particularly those from historically underserved groups. Given the significant improvements observed, further expansion of these benefits could help bridge income-based disparities in dental care use during pregnancy. However, the mixed results on birth outcomes suggest that coverage alone may not be sufficient to address disparities

related to race and ethnicity. Complementary strategies, such as targeted outreach, culturally tailored health education, and coordination between dental and prenatal care providers, are necessary to ensure that minority populations fully benefit from expanded coverage.

Moreover, extending Medicaid and Children's Health Insurance Program (CHIP) coverage to 12 months postpartum could further support maternal and child health by sustaining the oral health improvements achieved during pregnancy. Postpartum coverage would provide opportunities for continued preventive care, reducing the risk of long-term oral health issues that could negatively affect both the mother and her child. Integrating oral health services into routine prenatal care could also enhance the impact of Medicaid dental benefits. Encouraging collaboration between dental and prenatal care providers would allow for early detection and treatment of oral health issues, while implementing routine dental screenings during prenatal visits could address oral health concerns before they lead to adverse outcomes.

Targeted programs are needed to address the specific barriers faced by vulnerable populations, particularly rural and Hispanic mothers. The significant gains observed in rural areas in terms of birth outcomes suggest that targeted interventions, such as mobile dental clinics and telehealth services, could further improve access to care. Additionally, bilingual health education and culturally sensitive prenatal programs could help overcome barriers faced by Hispanic mothers, ensuring that they also benefit from expanded dental coverage. To ensure the ongoing effectiveness of these policies, robust monitoring and evaluation systems should be established to track both short-term and long-term impacts. Data-driven approaches would allow policymakers to identify gaps, assess program performance, and continuously improve the design and implementation of Medicaid dental benefits.

7 Conclusion

In conclusion, Medicaid pregnancy dental benefits have demonstrated their potential to improve maternal healthcare utilization and reduce some adverse birth outcomes, particularly among rural residents, younger mothers, and non-Hispanic Black individuals. However, the variability in policy impacts highlights the need for a comprehensive approach that integrates expanded coverage with targeted programs and complementary interventions. Addressing persistent disparities requires not only financial access through expanded benefits but also tailored outreach and education programs designed to meet the unique needs of diverse populations.

By incorporating continuous monitoring and evaluation systems, policymakers can ensure that programs remain effective and equitable. Expanding postpartum coverage

and integrating oral health services into prenatal care could further enhance the impact of Medicaid dental benefits. As policymakers seek to optimize maternal and child health outcomes, this study underscores the importance of leveraging Medicaid's potential as a powerful tool to reduce barriers to care, while recognizing the complexity of addressing disparities in health outcomes through policy interventions alone.

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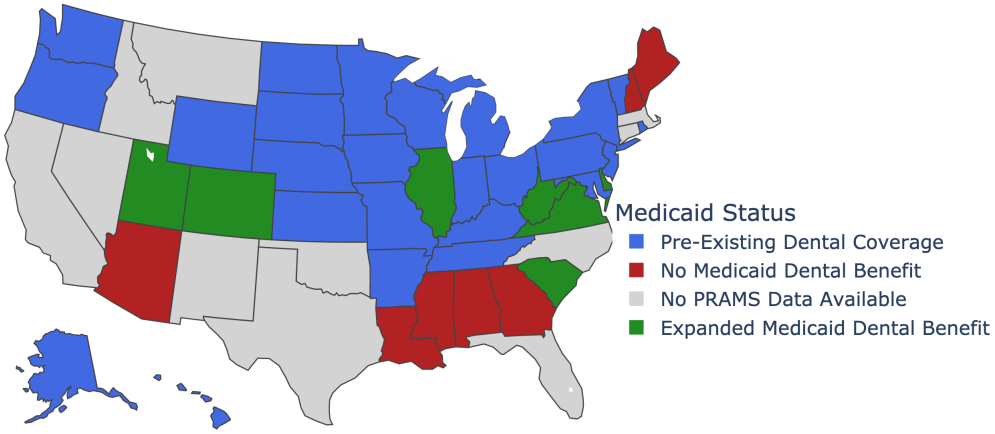
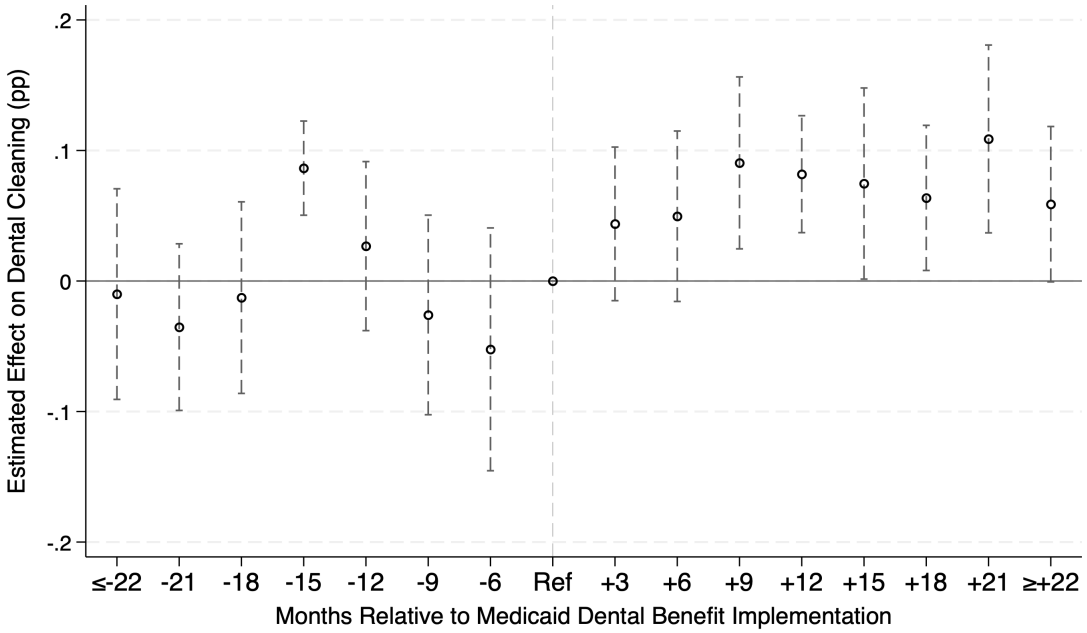
Figure 1: State Variation in Medicaid Pregnancy Dental Benefits, 2012–2022



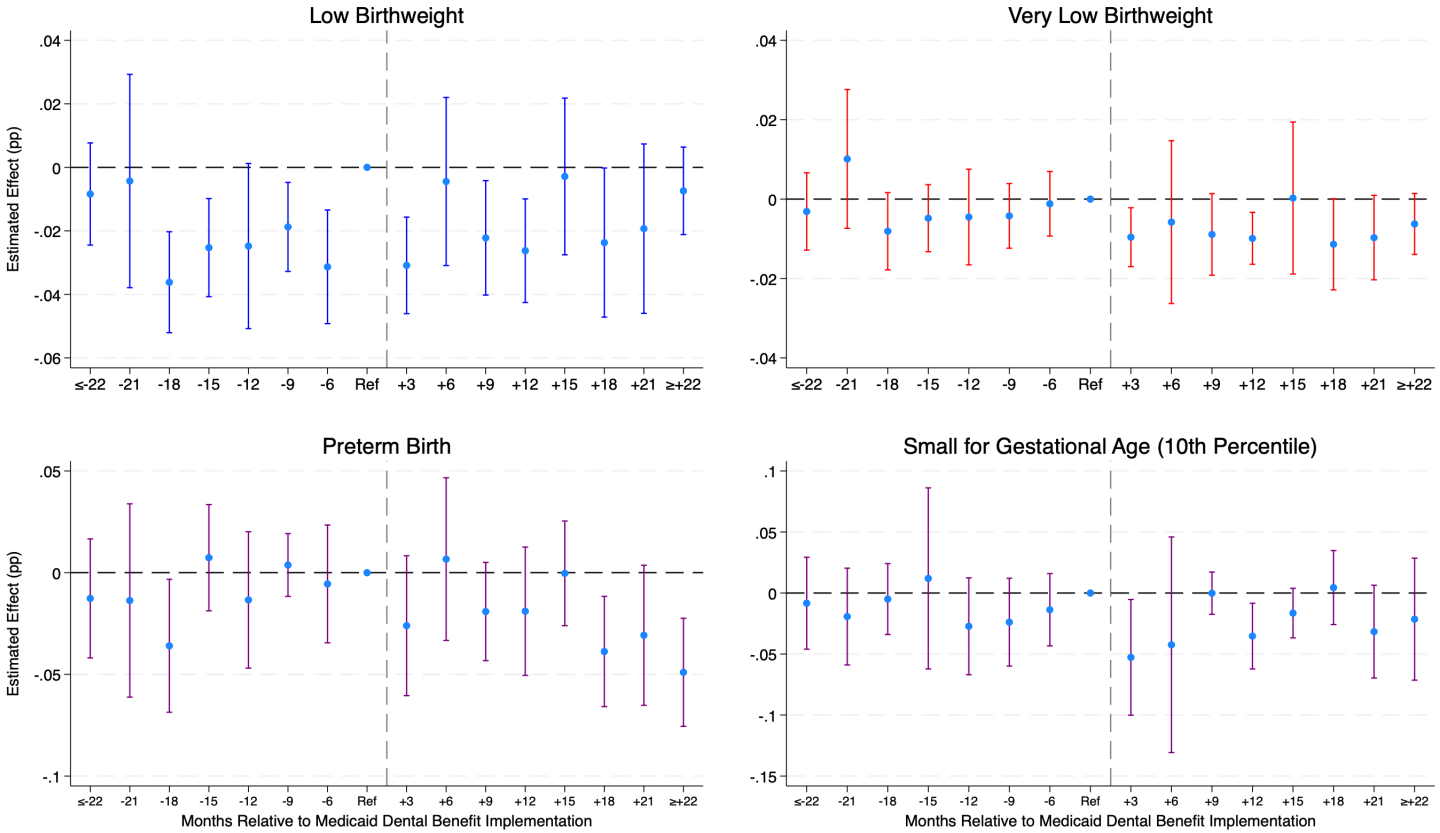
Notes: Data are from the Pregnancy Risk Assessment Monitoring System (PRAMS) and state-level Medicaid policy reports. The figure depicts the Medicaid pregnancy dental benefit status for each state during the study period.

Figure 2: Effect of Medicaid Pregnancy Dental Benefits on Dental Cleaning: Event Study Estimates



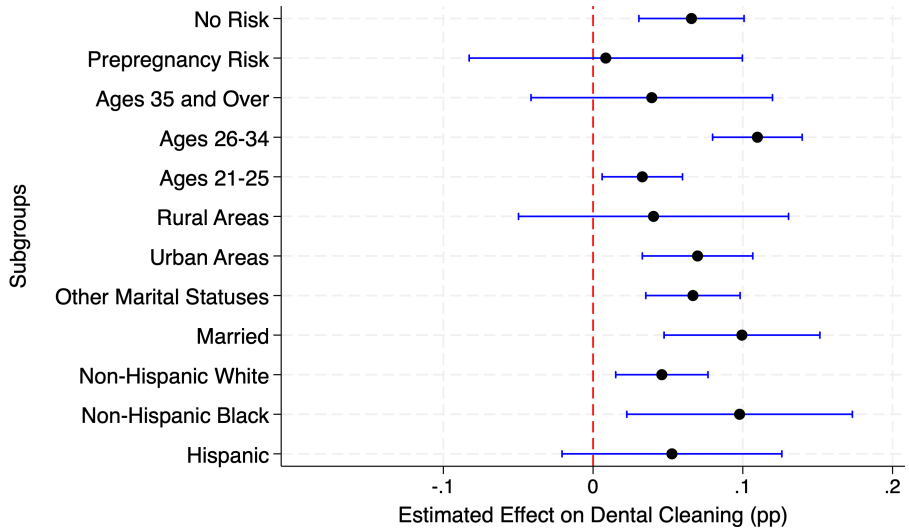
Notes: The figure displays event study estimates of the effect of Medicaid pregnancy dental benefit expansions on prenatal dental cleaning rates, using a stacked difference-in-differences approach. The x-axis represents time in months before and after policy adoption, and the y-axis shows the estimated coefficients. Confidence intervals are indicated by the vertical lines around the point estimates. The reference group is set to 0–3 months before policy implementation, and the estimates test the parallel trends assumption while capturing dynamic treatment effects.

Figure 3: Event Study Estimates: Effect of Medicaid Pregnancy Dental Benefits on Birth Outcomes



Notes: The figure presents event study estimates of the effect of Medicaid pregnancy dental benefits on key birth outcomes, including low birth weight, very low birth weight, preterm birth, and small for gestational age (10th percentile). Each panel corresponds to a separate outcome variable, with the x-axis representing time in months before and after policy implementation. The y-axis indicates the estimated coefficients, and vertical bars represent 95% confidence intervals. The reference group is set to 0–3 months before policy implementation. These estimates test the parallel trends assumption and provide dynamic treatment effects.

Figure 4: Heterogeneous Effects of Medicaid Pregnancy Dental Benefits on Dental Cleaning by Subgroup



Notes: The figure displays heterogeneous effects of Medicaid pregnancy dental benefits on prenatal dental cleaning rates across key subgroups, including racial/ethnic groups, age groups, marital statuses, and geographic locations. The estimated coefficients are plotted along with 95% confidence intervals. Subgroups with significant positive effects indicate populations that benefit most from the policy, while the vertical red line at zero denotes no effect.

Table 1: Sub-experiments of Medicaid dental benefit expansions for pregnant individuals

Sub-experiment Date	**Event Window**	**Treatment States**	**Control States**
10/2013	01/2012–10/2016	UT	DE, GA, ME, TN, WV, NH, AL, LA, MS
04/2014	01/2012–04/2017	CO	DE, GA, ME, TN, WV, NH, AL, LA, MS
07/2014	01/2012–07/2017	IL	DE, GA, ME, TN, WV, NH, AL, LA, MS
12/2014	01/2012–12/2017	SC	DE, GA, ME, TN, WV, NH, AL, LA, MS
03/2015	01/2012–03/2028	VA	DE, GA, ME, TN, WV, NH, AL, LA, MS

Notes: The table lists sub-experiments comparing treatment states with expanded benefits to control states without policy changes during the event window. The design captures pre- and post-policy effects.

Table 2: Summary Statistics

Variable	Mean	Std. Dev
Dental Care Utilization		
Received Dental Cleaning	0.443	0.497
Birth Outcomes		
Low Birthweight	0.077	0.267
Very Low Birthweight	0.013	0.114
Preterm Birth	0.093	0.290
Small for Gestational Age (10th Percentile)	0.109	0.312
Demographics		
Birth Order	1.009	0.098
Age of Mother	29.384	5.151
Lower than College Education	0.338	0.473
Non-Hispanic White	0.586	0.493
Non-Hispanic Black	0.176	0.381
Hispanic	0.145	0.353
Married	0.658	0.474
Urban Areas	0.797	0.402

Note: Summary statistics are based on PRAMS data from 2012 to 2019 for Medicaid-enrolled pregnant individuals aged 21 and older. The table provides means and standard deviations for birth outcomes, dental care utilization, and demographic characteristics.

Table 3: Effect of Medicaid Pregnancy Dental Benefits on Dental Cleaning and Birth Outcomes

	Dental Cleaning	Small for Gestational Age (P10)	Preterm Birth	Low Birth Weight	Very Low Birth Weight
Pregnancy Dental Benefit	0.0716***	-0.0119**	-0.00900	0.00503	-0.00470***
	(0.0138)	(0.00518)	(0.00633)	(0.00321)	(0.00147)
Baseline Mean	0.246	0.125	0.112	0.103	0.017
Observations	67068	61317	64282	67132	67132
R-squared	0.038	0.015	0.025	0.023	0.010

Notes: The table presents estimates of the effect of Medicaid pregnancy dental benefits on dental cleaning during pregnancy and key birth outcomes. Each column corresponds to results from a separate regression, with robust standard errors clustered at the state level shown in parentheses. The baseline mean is the average rate of each outcome in states without Medicaid pregnancy dental benefits. Covariates include maternal age, race/ethnicity, education, marital status, urban/rural residence, and pre-pregnancy risk factors, along with state-level controls such as Medicaid eligibility limits, managed care penetration, and broader contextual factors. State and year-by-month fixed effects account for unobserved heterogeneity across states and over time. Statistical significance is denoted as *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table 4: Stratified Estimates: Effect of Medicaid Pregnancy Dental Benefits

	All Sample	Low Education (≤ Associate)	High Education (≥ Bachelor's)	Income < $25k	Income ≥ $75k	Income ≤ $50k	Income ≥ $90k
Panel A: Dental Cleaning							
Pregnancy Dental Benefit	0.0420***	0.0572***	0.0362**	0.0355*	0.0262	0.0423**	0.0301
	(0.0110)	(0.0124)	(0.0117)	(0.0184)	(0.0194)	(0.0151)	(0.0199)
Observations	148811	54838	93973	56406	35374	84565	31430
R-squared	0.161	0.050	0.135	0.021	0.043	0.042	0.040
Panel B: Small for Gestational Age (P10)							
Pregnancy Dental Benefit	-0.00113	0.00442	-0.00342	0.00548	-0.00280	-0.00421	0.00339
	(0.00539)	(0.0107)	(0.00822)	(0.0109)	(0.0137)	(0.00766)	(0.0136)
Observations	135413	50555	84858	51836	31858	77389	28324
R-squared	0.013	0.013	0.009	0.011	0.012	0.013	0.012
Panel C: Preterm Birth							
Pregnancy Dental Benefit	0.00116	-0.00853	0.00640	-0.0104	0.00439	-0.00497	0.00532
	(0.00817)	(0.00984)	(0.00986)	(0.00922)	(0.00585)	(0.00739)	(0.00675)
Observations	143090	52829	90261	54203	34210	81203	30520
R-squared	0.018	0.021	0.015	0.024	0.013	0.020	0.012
Panel D: Low Birth Weight							
Pregnancy Dental Benefit	-0.00180	-0.0121**	0.00387	-0.00819	-0.00282	-0.00510*	-0.00188
	(0.00248)	(0.00394)	(0.00362)	(0.00495)	(0.00466)	(0.00250)	(0.00490)
Observations	148846	54871	93975	56400	35367	84553	31423
R-squared	0.020	0.017	0.019	0.020	0.010	0.018	0.008
Panel E: Very Low Birth Weight							
Pregnancy Dental Benefit	0.000368	-0.00189	0.00178	-0.00229	0.00276	-0.000717	0.00311*
	(0.00160)	(0.00138)	(0.00213)	(0.00267)	(0.00179)	(0.00262)	(0.00163)
Observations	148846	54871	93975	56400	35367	84553	31423
R-squared	0.007	0.008	0.007	0.009	0.008	0.007	0.005

Notes: The table presents stratified estimates of the effect of Medicaid pregnancy dental benefits on prenatal dental cleaning and birth outcomes. Each column represents a subgroup defined by education or income. Low education includes those with an associate degree or less; high education includes those with a bachelor's degree or more. Income categories are based on midpoint estimates of income brackets. All models control for demographics, state-level covariates, and year fixed effects. Standard errors are clustered at the state level. Statistical significance: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table 5: Effect of Medicaid Pregnancy Dental Benefits and Adult Medicaid Expansions on Dental Cleaning and Birth Outcomes

	Dental Cleaning	Small for Gestational Age (P10)	Preterm Birth	Low Birth Weight	Very Low Birth Weight
Pregnancy Dental Benefit	0.0734***	-0.00347	-0.000311	0.00301	-0.00422**
	(0.0269)	(0.00817)	(0.00559)	(0.00430)	(0.00187)
Non-Pregnant Medicaid Expansion	-0.00308	-0.0147*	-0.0151*	0.00349	-0.000819
	(0.0271)	(0.00858)	(0.00803)	(0.00492)	(0.00260)
Observations	67068	61317	64282	67132	67132
R-squared	0.038	0.015	0.025	0.023	0.010

Notes: This table presents estimates of the effects of (i) Medicaid pregnancy dental benefit adoption and (ii) non-pregnancy adult Medicaid expansions on prenatal dental cleaning and selected birth outcomes. Each column reports results from a separate regression controlling for maternal demographics, state-level economic and healthcare characteristics, and COVID-19 related measures. All regressions include state and year fixed effects and are weighted using survey weights. Standard errors clustered at the state level are shown in parentheses. Statistical significance is denoted as *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table 6: Effect of Medicaid Pregnancy Dental Benefits on Dental Cleaning and Birth Outcomes (Excluding Low-Income)

	Dental Cleaning	Small for Gestational Age (P10)	Preterm Birth	Low Birth Weight	Very Low Birth Weight
Pregnancy Dental Benefit	0.0899***	-0.0218**	-0.00809	-0.00828**	-0.00528**
	(0.0199)	(0.00825)	(0.0103)	(0.00399)	(0.00222)
Baseline Mean	0.282	0.109	0.101	0.086	0.014
Observations	31638	29276	30773	31693	31693
R-squared	0.057	0.019	0.030	0.021	0.011

Notes: This table presents estimates of the effect of Medicaid pregnancy dental benefits on prenatal dental cleaning and key birth outcomes, excluding individuals classified as **low income**. Each column corresponds to results from a separate regression, with robust standard errors clustered at the state level shown in parentheses. Covariates include maternal age, race/ethnicity, education, marital status, urban/rural residence, and pre-pregnancy risk factors, along with state-level controls such as Medicaid eligibility limits, managed care penetration, and broader contextual factors. State and year-by-month fixed effects account for unobserved heterogeneity across states and over time. Statistical significance is denoted as *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

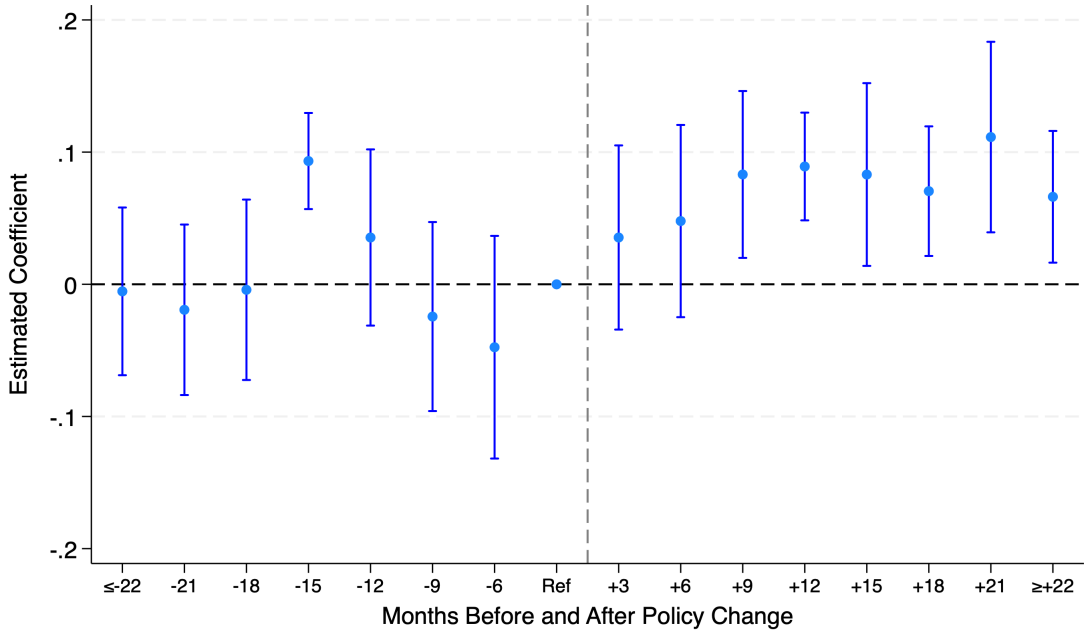
Table 7: Effect of Medicaid Pregnancy Dental Benefits on Prenatal Care and Smoking Behaviors

	Adequate Prenatal Care (Kotelchuck)	Maternal Smoking (Any)	Smoking 3 Months Before	Smoking Last 3 Months of Pregnancy	Non-Smoking After Pregnancy
Pregnancy Dental Benefit	-0.000125	0.0130	0.00921	0.0147	0.00275
	(0.0169)	(0.0148)	(0.0132)	(0.0146)	(0.0115)
Observations	62819	66003	66451	66507	66479
R-squared	0.038	0.171	0.195	0.174	0.170

Notes: The table presents estimates of the effect of Medicaid pregnancy dental benefits on prenatal care utilization and maternal smoking behaviors. The first column measures the probability of receiving adequate prenatal care based on the Kotelchuck Index (coded as a binary variable). The other columns reflect smoking status before, during, and after pregnancy. Each estimate is from a separate regression controlling for maternal demographics, state characteristics, and health service availability. All models include state and year fixed effects. Standard errors are clustered at the state level and reported in parentheses. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

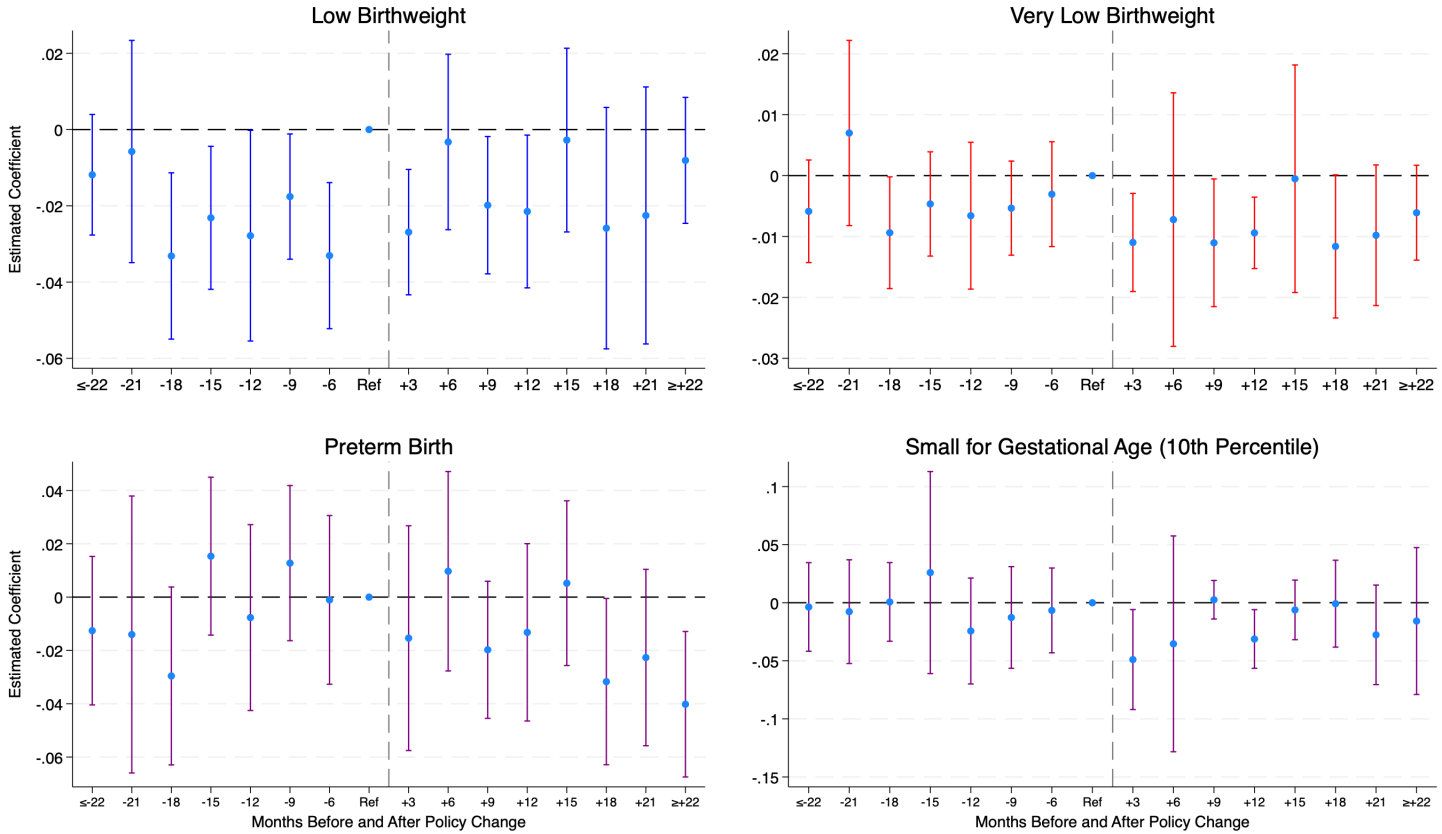
Appendix

Figure A.1: Effect of Medicaid Pregnancy Dental Benefits on Dental Cleaning: Event Study Estimates (Including Post-COVID-19 Period)



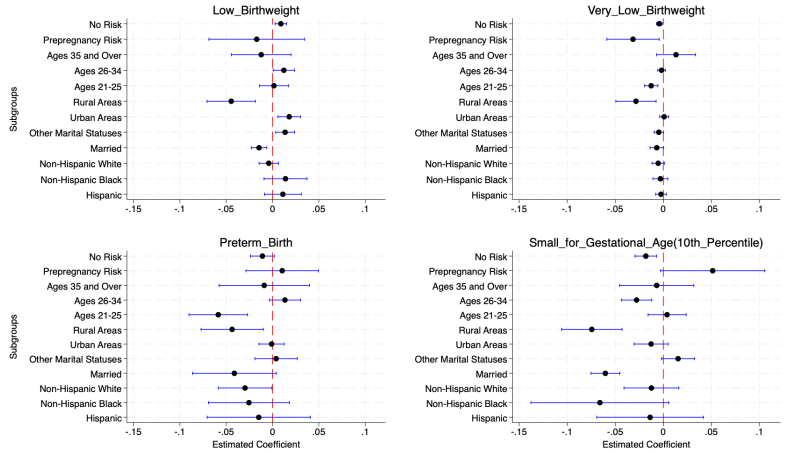
Notes: The figure displays event study estimates of the effect of Medicaid pregnancy dental benefit expansions on prenatal dental cleaning rates, using a stacked difference-in-differences approach with data including the post-COVID-19 period. The x-axis represents time in months before and after policy adoption, and the y-axis shows the estimated coefficients. Confidence intervals are indicated by the vertical lines around the point estimates. The reference group is set to 0–3 months before policy implementation. These estimates test the parallel trends assumption and provide dynamic treatment effects over time.

Figure A.2: Event Study Estimates: Effect of Medicaid Pregnancy Dental Benefits on Birth Outcomes (Including Post-COVID-19 Period)



Notes: The figure presents event study estimates of the effect of Medicaid pregnancy dental benefits on key birth outcomes, including low birth weight, very low birth weight, preterm birth, and small for gestational age (10th percentile), using data that includes the post-COVID-19 period. Each panel corresponds to a separate outcome, with the x-axis representing months before and after policy implementation. The y-axis shows the estimated coefficients, and vertical bars indicate 95% confidence intervals. The reference group is set to 0–3 months before policy implementation. These estimates assess the parallel trends assumption and capture dynamic treatment effects.

Figure A.3: Heterogeneous Effects of Medicaid Pregnancy Dental Benefits on Birth Outcomes by Subgroup



Notes: The figure displays the heterogeneous effects of Medicaid pregnancy dental benefits on key birth outcomes across subgroups, including demographic (age, race/ethnicity), geographic (urban vs. rural), and risk-based categories. Estimated coefficients for low birthweight, very low birthweight, preterm birth, and small for gestational age (10th percentile) are presented with 95% confidence intervals. Subgroups showing significant reductions or no changes provide insights into differential impacts. The vertical red line at zero represents no effect.

Table A.1: Effect of Medicaid Pregnancy Dental Benefits on Dental Cleaning (Stacked DID)

	(1)	(2)	(3)	(4)
Pregnancy Dental Benefit	0.0658***	0.0806***	0.0737***	0.0716***
	(0.0160)	(0.0127)	(0.0148)	(0.0138)
State	YES	YES	YES	YES
Year	YES	YES	YES	YES
Demographics		YES	YES	YES
Contextual Factors			YES	YES
Health Resources				YES
Observations	68840	67068	67068	67068
R-squared	0.016	0.037	0.038	0.038

Notes: The table reports estimates of the effect of Medicaid pregnancy dental benefits on prenatal dental cleaning using a stacked difference-in-differences (SDID) design. Each column corresponds to a separate regression, sequentially adding control variables: demographics, contextual factors, and health resources. All models include state and year fixed effects and are weighted by survey weights. Robust standard errors clustered at the state level are reported in parentheses. Statistical significance is denoted as *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table A.2: Effect of Medicaid Pregnancy Dental Benefits on Dental Cleaning (TWFE)

	(1)	(2)	(3)	(4)
Pregnancy Dental Benefit	0.0757***	0.105***	0.0974***	0.0776***
	(0.0233)	(0.0168)	(0.0173)	(0.0160)
State	YES	YES	YES	YES
Year	YES	YES	YES	YES
Demographics		YES	YES	YES
Contextual Factors			YES	YES
Health Resources				YES
Observations	30437	28758	28758	28758
R-squared	0.016	0.032	0.032	0.033

Notes: The table reports estimates of the effect of Medicaid pregnancy dental benefits on prenatal dental cleaning using a traditional two-way fixed effects (TWFE) design. Each column adds further controls: demographics, contextual factors, and health resources. Models are weighted and include state and year fixed effects. Standard errors are clustered at the state level. Statistical significance is denoted as *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table A.3: Effect of Medicaid Pregnancy Dental Benefits on Prenatal Dental Cleaning and Birth Outcomes (Including Post-COVID-19 Period)

	Dental Cleaning	Small for Gestational Age (P10)	Preterm Birth	Low Birth Weight	Very Low Birth Weight
Pregnancy Dental Benefit	0.0663***	-0.0149***	-0.00758	0.00693**	-0.00427**
	(0.0151)	(0.00506)	(0.00551)	(0.00304)	(0.00164)
Baseline Mean	0.242	0.123	0.114	0.105	0.017
Observations	95582	87430	91572	95653	95653
R-squared	0.039	0.014	0.026	0.023	0.010

Notes: The table presents estimates of the effect of Medicaid pregnancy dental benefits on dental cleaning during pregnancy and key birth outcomes using data that includes the post-COVID-19 period. Each column corresponds to results from a separate regression, with robust standard errors clustered at the state level shown in parentheses. The baseline mean is the average rate of each outcome in states without Medicaid pregnancy dental benefits. Covariates include maternal age, race/ethnicity, education, marital status, urban/rural residence, and pre-pregnancy risk factors, along with state-level controls such as Medicaid eligibility limits, managed care penetration, and broader contextual factors. State and year fixed effects account for unobserved heterogeneity across states and over time. Statistical significance is denoted as *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table A.4: Intent-to-Treat Estimates: Effect of Medicaid Pregnancy Dental Benefits on Dental Cleaning and Birth Outcomes (Full Insurance Sample)

	Dental Cleaning	Small for Gestational Age (P10)	Preterm Birth	Low Birth Weight	Very Low Birth Weight
Pregnancy Dental Benefit	0.0350***	0.000495	0.00330	0.00670**	-0.000273
	(0.00807)	(0.00433)	(0.00289)	(0.00252)	(0.00104)
Baseline Mean	0.422	0.101	0.093	0.079	0.013
Observations	148811	135413	143090	148846	148846
R-squared	0.163	0.014	0.019	0.020	0.007

Notes: The table presents intent-to-treat (ITT) estimates of the effect of Medicaid pregnancy dental benefit expansions on prenatal dental cleaning and birth outcomes using the full insurance sample, which includes individuals with Medicaid, private, or other forms of insurance. Each column reports results from a separate regression of the outcome on the dental benefit policy indicator. All models adjust for maternal demographics (age, education, marital status, race/ethnicity, urban/rural residence, pre-pregnancy health risk), state-level characteristics (fertility rate, managed care penetration, dental provider supply, unemployment rate) and health service factors (ACA expansion, dentist availability). State and year fixed effects are included. Robust standard errors are clustered at the state level and reported in parentheses. Baseline means represent average outcomes in states without pregnancy dental benefits. Statistical significance is denoted as *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table A.5: Effect of Medicaid Pregnancy Dental Benefits on Dental Cleaning and Birth Outcomes (Self-Reported + Birth Certificate Medicaid)

	Dental Cleaning	Small for Gestational Age (P10)	Preterm Birth	Low Birth Weight	Very Low Birth Weight
Pregnancy Dental Benefit	0.0673***	0.000789	-0.00350	0.00880**	-0.00325*
	(0.0133)	(0.00439)	(0.00664)	(0.00426)	(0.00165)
Baseline Mean	0.253	0.122	0.111	0.101	0.016
Observations	74233	67809	71136	74292	74292
R-squared	0.036	0.014	0.022	0.021	0.009

Notes: This table presents estimates of the effect of Medicaid pregnancy dental benefits on dental cleaning during pregnancy and key birth outcomes, using a sample that includes both self-reported Medicaid coverage and birth certificate Medicaid coverage. Each column corresponds to results from a separate regression, with robust standard errors clustered at the state level shown in parentheses. The baseline mean is the average rate of each outcome in states without Medicaid pregnancy dental benefits. Covariates include maternal age, race/ethnicity, education, marital status, urban/rural residence, and pre-pregnancy risk factors, along with state-level controls such as Medicaid eligibility limits, managed care penetration, and broader contextual factors. State and year fixed effects account for unobserved heterogeneity across states and over time. Statistical significance is denoted as *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table A.6: Leave-One-Out Estimates: Effect of Medicaid Pregnancy Dental Benefits

	Full Sample	Excl. UT	Excl. IL	Excl. CO	Excl. VA	Excl. SC
Panel A: Dental Cleaning						
Pregnancy Dental Benefit	0.0716***	0.0812***	0.0437*	0.0654***	0.0764***	0.0716***
	(0.0138)	(0.00959)	(0.0231)	(0.0173)	(0.0161)	(0.0138)
Observations	67068	65470	64822	65030	66180	67068
R-squared	0.038	0.035	0.043	0.039	0.038	0.038
Panel B: Small for Gestational Age (P10)						
Pregnancy Dental Benefit	-0.0119**	-0.0148***	-0.00295	-0.0108	-0.0162***	-0.0119**
	(0.00518)	(0.00522)	(0.00728)	(0.00677)	(0.00572)	(0.00518)
Observations	61317	59778	59168	59391	60476	61317
R-squared	0.015	0.015	0.015	0.015	0.014	0.015
Panel C: Preterm Birth						
Pregnancy Dental Benefit	-0.00900	-0.00937	-0.0178*	-0.0104*	-0.0169***	-0.00900
	(0.00633)	(0.00736)	(0.00927)	(0.00602)	(0.00464)	(0.00633)
Observations	64282	62684	62039	62246	63393	64282
R-squared	0.025	0.025	0.026	0.026	0.023	0.025
Panel D: Low Birth Weight						
Pregnancy Dental Benefit	0.00503	0.00443	0.00470	0.00606*	0.00604	0.00503
	(0.00321)	(0.00327)	(0.00450)	(0.00357)	(0.00393)	(0.00321)
Observations	67132	65534	64886	65097	66241	67132
R-squared	0.023	0.023	0.022	0.023	0.023	0.023
Panel E: Very Low Birth Weight						
Pregnancy Dental Benefit	-0.00470***	-0.00559***	-0.00609**	-0.00337**	-0.00397**	-0.00470***
	(0.00147)	(0.00147)	(0.00252)	(0.00145)	(0.00157)	(0.00147)
Observations	67132	65534	64886	65097	66241	67132
R-squared	0.010	0.010	0.010	0.010	0.010	0.010

Notes: This table presents leave-one-out stacked difference-in-differences (SDID) estimates of the effect of Medicaid pregnancy dental benefits on various maternal and birth outcomes. Each column excludes one treated state at a time. Standard errors are clustered at the state level and shown in parentheses. Statistical significance is denoted as *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table A.7: Placebo Test: Effect of Medicaid Pregnancy Dental Benefits on Dental Cleaning and Birth Outcomes (Private Insurance Sample)

	Dental Cleaning	Small for Gestational Age (P10)	Preterm Birth	Low Birth Weight	Very Low Birth Weight
Pregnancy Dental Benefit	0.00625	0.00447	0.00306	0.00963***	0.00397***
	(0.0224)	(0.00566)	(0.00737)	(0.00332)	(0.00133)
Baseline Mean	0.611	0.079	0.073	0.056	0.010
Observations	58626	53232	56654	58614	58614
R-squared	0.094	0.013	0.016	0.010	0.008

Notes: This table presents placebo test estimates of the effect of Medicaid pregnancy dental benefits on dental cleaning during pregnancy and key birth outcomes using the private insurance sample. Because private insurance enrollees are not subject to Medicaid dental expansions, significant estimates would suggest potential confounding or broader trends. Each column corresponds to results from a separate regression, with robust standard errors clustered at the state level shown in parentheses. Covariates include maternal age, race/ethnicity, education, marital status, urban/rural residence, and pre-pregnancy risk factors, along with state-level controls such as Medicaid eligibility limits, managed care penetration, COVID-19 contextual factors, and broader socioeconomic indicators. State and year fixed effects are included. Statistical significance is denoted as *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table A.8: Balance Test: Covariate Differences by Medicaid Pregnancy Dental Benefit Status

	Hispanic	Non-Hispanic Black	Non-Hispanic White	Non-Hispanic Other	Ages 21–25	Ages 26–34	Ages 35 and Over	Married	Other Marital Status	Urban Areas	Rural Areas
Pregnancy Dental Benefit	-0.0404**	-0.00877	0.0227	0.0264	0.0661***	-0.0801***	0.0141*	-0.0174	0.0174	-0.0250*	0.0250*
	(0.0197)	(0.00721)	(0.0488)	(0.0565)	(0.0230)	(0.0211)	(0.00790)	(0.0124)	(0.0124)	(0.0146)	(0.0146)
Observations	67141	67141	67141	67141	67141	67141	67141	67141	67141	67141	67141
R-squared	0.099	0.118	0.130	0.415	0.015	0.009	0.012	0.030	0.030	0.113	0.113
	Low Education	High Education	Low Income	Low Middle Income	Middle Income	Upper Income	High Income	Other Income	Prepregnancy Risk	No Risk	Missing Risk Info
Pregnancy Dental Benefit	0.0280	-0.0280	-0.00710	0.0312**	-0.0330*	0.0291***	-0.000825	0.0291***	-0.0177	0.00323	0.0144
	(0.0332)	(0.0332)	(0.0167)	(0.0126)	(0.0176)	(0.00728)	(0.00285)	(0.00728)	(0.0137)	(0.00552)	(0.0123)
Observations	67141	67141	67141	67141	67141	67141	67141	67141	67141	67141	67141
R-squared	0.011	0.011	0.074	0.017	0.040	0.034	0.006	0.034	0.450	0.018	0.832

Notes: The table reports results from balance tests assessing differences in baseline characteristics between states with and without Medicaid pregnancy dental benefits. Each cell presents the estimated coefficient from a separate regression of the specified characteristic on the Medicaid dental benefit indicator, controlling for time-varying state-level covariates. All models include state and year fixed effects. Standard errors clustered at the state level are shown in parentheses. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.1$.