

IN THE SUPREME COURT OF OHIO

STATE ex rel. CLEVELAND RIGHT  
TO LIFE, INC. et al.

Case No. 13-1668

Relators

Original Action in Mandamus and  
Prohibition

v.

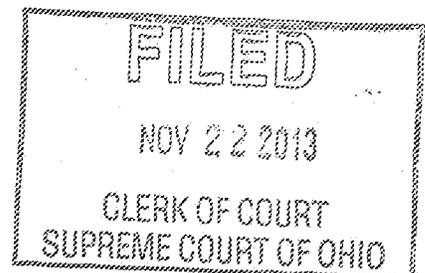
STATE OF OHIO CONTROLLING  
BOARD, et al.

Respondents.

BRIEF IN SUPPORT OF RESPONDENTS BY AMICI: AMERICAN CANCER SOCIETY CANCER ACTION NETWORK; NATIONAL ASSOCIATION OF SOCIAL WORKERS-OHIO; NATIONAL HEALTH LAW PROGRAM; NATIONAL MULTIPLE SCLEROSIS SOCIETY OHIO CHAPTERS; OHIO ASSOCIATION OF AREA AGENCIES ON AGING; OHIO OLMSTEAD TASK FORCE; OHIO VOICES FOR CHILDREN; PEOPLE FIRST OF OHIO; POLICY MATTERS OHIO; THE ARC OF OHIO; THE CENTER FOR COMMUNITY SOLUTIONS; THE COALITION ON HOMELESSNESS AND HOUSING IN OHIO (COHHIO); THE FRANKLIN COUNTY PUBLIC DEFENDER; THE OHIO EMPOWERMENT COALITION; THE OHIO FEDERATION OF TEACHERS; TOLEDO AREA JOBS WITH JUSTICE & INTERFAITH WORKER JUSTICE COALITION; TOLEDO/LUCAS COUNTY CARENET; UNIVERSAL HEALTH CARE ACTION NETWORK OF OHIO (UHCAN OHIO); ADVOCATES FOR BASIC LEGAL EQUALITY, INC.; COMMUNITY LEGAL AID SERVICES, INC.; DISABILITY RIGHTS OHIO; LEGAL AID OF WESTERN OHIO; LEGAL AID SOCIETY OF SOUTHWEST OHIO, LLC; SOUTHEASTERN OHIO LEGAL SERVICES; THE LEGAL AID SOCIETY OF CLEVELAND; THE LEGAL AID SOCIETY OF COLUMBUS; and OHIO POVERTY LAW CENTER, LLC

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## **I. STATEMENT OF INTEREST OF AMICI CURIAE**

Advocates for Basic Legal Equality, Inc.; Community Legal Aid Services, Inc.; Southeastern Ohio Legal Services; The Legal Aid Society of Cleveland; The Legal Aid Society of Columbus; Legal Aid Society of Southwest Ohio, LLC; Pro Seniors, Inc. and Ohio Poverty Law Center, LLC are nonprofit, nonpartisan legal services organizations that represent low-income individuals throughout Ohio in connection with medical and other civil problems they have. Disability Rights Ohio is an organization designated under federal law as the system to protect and advocate the rights of people with disabilities and advocates for the human, civil, and legal rights of people with disabilities in Ohio.

Additional amici on this brief advocate for a wide range of individuals without adequate health insurance and who would benefit from the Medicaid expansion challenged by Relators. These additional amici are: American Cancer Society Cancer Action Network; National Association of Social Workers–Ohio; National Health Law Program; National Multiple Sclerosis Society Ohio Chapters; Ohio Association of Area Agencies on Aging; Ohio Olmstead Task Force; Ohio Voices for Children; Policy Matters Ohio; People First of Ohio; The ARC of Ohio; The Center for Community Solutions; The Coalition on Homelessness and Housing in Ohio (COHHIO); The Franklin County Public Defender; The Ohio Empowerment Coalition; The Ohio Federation of Teachers; Toledo Area Jobs with Justice & Interfaith Worker Justice Coalition; Toledo/Lucas County CareNet; Universal Health Care Action Network of Ohio (UHCAN Ohio). Appendix A (at 21–24) describes the interests of some of these amici.

There are approximately 360,000 Ohioans who do not have any health insurance and are not enrolled in Medicaid (See ¶2 of Relator’s Complaint and Appendix B at 25). Amici are filing this Brief to protect the interests of all low-income adults in Ohio under 65 years of age who do not have health insurance or current Medicaid coverage but who will become eligible

under the Medicaid expansion on January 1, 2014. The expansion of Medicaid starting January 1, 2014, will provide these low-income individuals with crucial medical services, including preventive services, which will make these individuals more employable and healthier and will, in fact, save lives.

## **II. STATEMENT OF FACTS**

On October 10, 2013, the federal government approved Ohio's Medicaid State Plan for Ohio to serve consumers eligible for the Medicaid expansion (Appendix C at 26–28).

On October 21, 2013, the Department of Medicaid submitted to the Controlling Board an Authorization Requested Pursuant to Revised Code Section 131.35 “to increase appropriation authority in fund 3F00, ALI 6561623, Medicaid Services-Federal, by \$561,700,000 in SFY2014 and \$1,999,500,000 in SFY15” (the “Request”) to carry out the approved state plan and stated:

“This appropriation would provide Medicaid coverage to adults without dependent children between 0%–138% of the Federal Poverty Level (FPL) and parents otherwise not covered by current Medicaid eligibility levels up to 138% FPL. These individual are enumerated in the Department of Medicaid's State Plan Amendment on eligibility as approved by the federal Centers for Medicare and Medicaid Services (CMS) on October 10, 2013)

The Social Security Act, section 1905(y), 42 USC1396d(y), provides 100 percent federal funding for the newly eligible group in the state fiscal year 2014 and 2015 biennium. If this federal assistance percentage is lowered, state funds will not be used to supplant federal funds.” (Exhibit A to Relator's Complaint).

On October 21, 2013, the Controlling Board approved the Request.<sup>1</sup>

On October 22, 2014, the Relators filed this action.

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<sup>1</sup> ¶5 of Relator's Complaint admitted the Controlling Board approved the Request. Amici disagree with Relators that the approval was void or unlawful.

### **III. ARGUMENT**

#### **A. RELATORS HAVE NO LEGAL RIGHT TO THE RELIEF REQUESTED, BECAUSE OHIO REVISED CODE §§5162.05, 5163.03 AND 131.35 AUTHORIZE THE ACTIONS OF THE DEPARTMENT OF MEDICAID AND THE CONTROLLING BOARD**

O.R.C. §5162.05 (approved as part of Amended Substitute HB 59) provides, “The medicaid program shall be implemented in accordance with ... (A) The medicaid state plan approved by the United States secretary of health and human services...” As set forth above, Ohio’s Medicaid state plan approved by the federal government includes the Medicaid expansion being challenged by Relator (Appendix C at 26).

O.R.C. §5163.03 (approved as part of Amended Substitute HB 59) authorizes Ohio’s Medicaid program to “cover any of the optional eligibility groups to which either of the following applies: (1) State statutes expressly permit the medicaid program to cover the optional eligibility group. (2) State statutes do not address whether the medicaid program may cover the optional eligibility group.”

O.R.C. §131.35(A)(1) provides that a state agency may make expenditures of federal funds that “are authorized by the controlling board pursuant to division (A)(5) of this section....” O.R.C. §131.35(A)(2) provides, “If the federal funds received are greater than the amount of such funds appropriated by the general assembly for a specific purpose, ... the expenditure of federal funds received in excess of such specific appropriation may be authorized by the controlling board.” O.R.C. §131.35(A)(5) provides, “Controlling board authorization for a state agency to make an expenditure of federal funds constitutes authority for the agency to participate in the federal program providing the funds, and the agency is not required to obtain an executive order under section 107.17 of the Revised Code to participate in the federal program....”

Amici adopt and incorporate by reference here the arguments of Respondents that Relators have no legal right to a writ of mandamus under the basic three requirements (clear legal right to relief of relator, clear legal duty by respondents and no adequate remedy at law) set forth in *State ex rel. Hoffman v. Rexam Beverage Can Co.*, 2013 WL 5647634 (Ohio), 2013-Ohio-4538, ¶13 and *State ex rel. Gen. Motors Corp. v. Indus. Comm.*, 117 Ohio St.3d 480, 2008-Ohio-1593, ¶9. Part B of this argument shows that in deciding on a request for mandamus, courts should take into account the interests of the consumer beneficiaries of the Medicaid expansion—the only individuals whose lives are at stake. This consideration confirms that the Court should reject the suit of Relators.

**B. BALANCING THE THREAT TO THE LIVES OF LOW-INCOME OHIOANS WHO HAVE A RIGHT TO START RECEIVING MEDICAID EXPANSION ON JANUARY 1, 2014, AGAINST THE INTERESTS OF RELATORS—WHO ADMIT THEY HAVE “NO RIGHTS OR OBLIGATIONS PECULIAR” TO THEM—CONFIRMS THAT NO WRIT OF MANDAMUS SHOULD ISSUE**

The Supreme Court has made clear that after considering the three basic requirements for mandamus, a court should then consider whether—in the exercise of discretion—to issue the requested writ, taking into account the interests of third parties and whether issuing the writ will promote justice. For instance, in *State ex rel. Pressley v. Industrial Commission of Ohio*, 11 Ohio St.2d 141, 228 N.E.2d 631 (1967), ¶7 of syllabus, the court held, “The Supreme Court ... in considering the allowance or denial of the writ of mandamus on the merits, will exercise sound, legal and judicial discretion based upon all the facts and circumstances in the individual case and the justice to be done.” In *State ex rel. Gerspacher v. Coffinberry*, 157 Ohio St. 32, 104 N.E.2d 1 (1952), ¶3 of syllabus, the Court held, “The issuance of a writ of mandamus rests largely within the sound discretion of the court.” See also, *State ex rel. Fenske v. McGovern*, 11 Ohio St.3d 129, 131, 464 N.E.2d 525 (1984) (cited by Relators at 27 and saying “considered by the court in exercising its discretion whether a writ should issue”); and *State ex rel. Dollison v.*

*Reddy*, 55 Ohio St.2d 59, 378 N.E.2d 150 (1978) (“one element in exercising its discretion whether the writ should issue”).

In exercising discretion in a mandamus action, a court must consider the interests of third parties and whether issuing a writ would promote justice. In *Pressley*, the Court said, “Among the facts and circumstances which the court will consider are the applicant's rights, the interests of third persons, the importance or unimportance of the case, the applicant's conduct, the equity and justice of the relator's case, public policy and the public's interest, ...” (Emphasis added). *Id.* at 162. In *Pressley*, the Court also said that a writ of mandamus “must not be so exercised as to defeat the rights of persons clearly recognized and supported by sound and well established principles of law.” *Id.* Similarly, in *State ex rel. Mettler v. Stratton*, 139 Ohio St. 86, 88 (1941), the Court said that:

“regard will be had to the exigency which calls for the exercise of such discretion, the nature and extent of the wrong or injury which would follow a refusal of the writ, and other facts which have a bearing on the particular case. The court may consider the applicant's rights, the interests of third persons, the importance or unimportance of the case, and the applicant's conduct, in determining whether the writ shall issue.”

Amici discuss these factors in sections 1–4 below.

1. **Indigent Adults Throughout Ohio Not Fitting Into a Current Category of Eligibility Have No Source of Health Insurance or Non-Emergency Medical Services Except the Medicaid Expansion**

Medicaid is a program of cooperative federalism in which states develop a plan, approved by the federal government, to provide medical assistance to a variety of “groups” of low-income individuals pursuant to 42 U.S.C. §1396a. Such plans include coverage for, among others, (1) families with minor children, (2) pregnant women, 42 U.S.C. §1396a(a)(10)(A)(i)(III)–(V), and (3) certain adults with severe disabilities whose disabilities prevent them from being employable for at least 12 months. 42 U.S.C. §1396d. The states and the federal government

share in the cost of providing medical assistance. *See* 42 U.S.C. §1396b. Until the enactment of the Patient Protection and Affordable Care Act of 2010 (the “ACA”), adults who did not “fit” into one of these three categories were generally not eligible for Medicaid. Thanks to the expansion of the ACA, as of January 1, 2014, adults without minor children whose income (if any) does not exceed 138% of the Federal Poverty Level will be eligible for Medicaid, pursuant to what is commonly referred to as the “Medicaid expansion.” *See* Patient Protection and Affordable Care Act §2001(a)(1)(C) (codified at 42 U.S.C. §1396a(a)(10)(A)(i)(VIII)(Supp. IV 2011)). Unlike other categories of Medicaid, the expansion will be funded completely by the federal government for the first three years, beyond the period covered by the challenged action of the Controlling Board, and the federal government has agreed that Ohio is not bound to the expansion after that period (42 U.S.C. §1396d(y) and Appendix D at 29).

There is a current category of Medicaid for adults in Ohio whose disabilities are so severe that they have been determined to be unemployable for 12 months due to the disability or disabilities of the individual and who meet certain financial eligibility criteria (“ABD Medicaid”). *See* 42 U.S.C. §§1396d, 1382c. However, many Ohioans have disabilities not severe enough to qualify for ABD Medicaid, or are financially ineligible for that program (Appendix E at 30–31). The Medicaid expansion will cover those individuals with disabilities who do not qualify for ABD Medicaid and are below 138% of the Federal Poverty Level. 42 U.S.C. §1396a(a)(10)(A)(i)(VIII), 42 U.S.C. §1397jj(c)(5) and 42 C.F.R. §435.603(d).

Under other provisions of the ACA, individuals with income between 100 and 400% of 100% of the Federal Poverty Level can receive subsidies in the form of Federal tax credits to make the purchase of health insurance more affordable through market exchanges in each of the states. 26 U.S.C. §36B. However, individuals whose income is at or below the FPL are not

eligible for any tax credits or subsidies for the purchase of health insurance, since the Affordable Care Act anticipated such individuals would receive Medicaid through the expansion. 26 U.S.C. §36B(c) (defining the term “applicable taxpayer”). In other words, if Relators were to be successful, the government would treat Ohioans under 100% of the Federal Poverty Level worse than Ohioans with higher incomes.

The next part of this Brief summarizes the harm these Ohioans would suffer as a result of blocking the Medicaid expansion.

2. **Indigent Adults Throughout Ohio Under 65 Would Suffer Extreme Emotional Distress, Would Deteriorate Physically, and Some Would Die If This Court Granted the Requested Writ**

Looking at the experience of a few states that previously expanded Medicaid coverage to adults, in January 2013, the Kaiser Commission on Medicaid and the Uninsured found that the Medicaid expansion on January 1, 2014, would “have significant positive impacts on individuals’ personal lives by enabling them to obtain needed care, providing financial protection from the cost of care, and alleviating a significant source of stress and worry.” (Appendix G at 34–36). The Commission, part of one of the oldest and most respected health care organizations in the country, concluded that expansion helped individuals get their lives under control to “focus on other priorities and goals, including employment.” *Id.* at 36. The Commission also discussed the negative effects on the lives of those individuals without health insurance: “waiting until conditions worsened or became unbearable before seeking care and frequently relying on the emergency room when they did seek care, which resulted in large bills they could not pay. Moreover, a number said they were unable to obtain recommended follow-up care after receiving emergency treatment.” *Id.* at 35.

In fact, for years, health authorities have recognized the importance of preventive care and early detection and treatment of medical problems. In 2001, Steven H. Woolf, M.D.,

M.P.H., and David Atkins, M.D., M.P.H., members of the U.S. Preventive Services Task Force, concluded that: “Many of the leading causes of death and disability in the United States can be prevented ... Primary prevention can prevent or arrest the disease process in its earliest stages by promoting healthier lifestyles or immunizing against infectious disease. Secondary prevention, by detecting and treating asymptomatic risk factors or early asymptomatic disease, can substantially reduce subsequent morbidity or mortality.” (Appendix H at 37) (Emphasis added).

Pre-eminent health authorities continue to recognize the importance of preventive care and early detection and treatment. In October 2013, The Kaiser Commission issued another report and said, “Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy people are. Uninsured adults are far more likely than those with insurance to postpone or forgo health care altogether. The consequences can be severe, particularly when preventable conditions go undetected.” (Appendix I: “The Uninsured—A Primer”, at 38–39). The Kaiser Commission continued, “Because people without health coverage are less likely than those with insurance to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and experience declines in their overall health.” *Id.* at 39 (Emphasis added).

The critical importance of early detection and treatment spans the range of medical problems women and men can face, and those conditions generally go undetected when individuals do not have health insurance. For instance, the U.S. Preventive Services Task Force has published on-line cervical cancer screening recommendations, including, “Women aged 21 to 65 should be screened with cytology (commonly known as a Pap smear) every 3 years. As an alternative, women aged 30 to 65 who want to be screened less frequently may choose the combination of cytology and human papillomavirus (HPV) testing every 5 years, which offers

similar benefits to cytology only. This is an A recommendation.” (Appendix J at 40). The recommendations continued, “Since the implementation of widespread cervical cancer screening, there has been a dramatic reduction in cervical cancer deaths in the United States. ‘About half of women diagnosed with this disease have never had a Pap smear or have not been adequately screened. Therefore, it is important for clinicians and health care systems to get women into screenings who have never been screened, or who have not been screened in the last 5 years,’ said Task Force member Wanda Nicholson, M.D., M.P.H., M.B.A.” *Id.* (Emphasis added). The Medicaid expansion will help address this threat to women.

The Robert Wood Johnson Foundation, the largest philanthropy devoted exclusively to health and health care, reported that critical gaps in mental health coverage exist in the United States, “leaving many people at risk for lifelong disabilities, hospitalization, jail time, or suicide. Early detection and treatment of serious mental illnesses works, but more must be done to implement this model throughout the health care and social service systems.” (Appendix K, Emphasis added, at 41). The report continued, “Seventy-five percent of people with schizophrenia go on to develop a disability and fewer than 25 percent are gainfully employed.” *Id.* The Medicaid expansion will forestall this tragic deterioration of many Ohioans.

The National Institutes of Health (“NIH”), the largest source of funding for medical research in the world, has published Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents recommending Antiretroviral therapy (ART) for the treatment of HIV infection (Appendix L at 42–44). In the Introduction of these guidelines, NIH explained, “ART has dramatically reduced HIV-associated morbidity and mortality and has transformed HIV disease into a chronic, manageable condition.” *Id.* at 43. (Emphasis added). At E-1 of the Guidelines, NIH states, “Without treatment, the vast majority of HIV-infected individuals will

eventually develop progressive immunosuppression (as evident by CD4 count depletion), leading to AIDS-defining illnesses and premature death.” *Id.* at 44. (Emphasis added). If Relators were successful in blocking or delaying the Medicaid expansion, an untold number of Ohioans eligible for the Medicaid expansion will have their HIV infection undetected and will deteriorate physically and, eventually, die. The Medicaid expansion will prevent the expansion of this scourge.

The Institute of Medicine, an independent nonprofit organization that is the health arm of the National Academies of Sciences (chartered by President Lincoln in 1863), addressed the harmful effects of lack of insurance on other specific diseases (Appendix M at 45–46). The Institute found that uninsured adults are more likely than insured adults: (1) “to suffer extremely poor outcomes, including neurological impairment, intracerebral hemorrhage, and death” in response to acute ischemic stroke; and (2) “to be diagnosed at an advanced stage of cancer.” In addition, the Institute found that uninsured adults: (1) “are at greater risk of death than insured adults” in connection with congestive heart failure; (2) with diabetes “have significantly worse glycemic control than insured adults”; (3) “are more likely than insured adults to die after heart attack”; (4) who are inpatients in hospitals with serious acute conditions “are at greater risk than insured adults of higher mortality in hospital and for at least 2 years after admission”; and (5) “are less likely than insured adults to be aware of hypertension and, if hypertensive, more likely to have inadequate blood pressure control.” *Id.* at 46. Finally, the Institute found, “Uninsured adults in severe automobile accidents have a substantially higher mortality rate.” *Id.*

A number of national reports have gone further and identified the number of deaths attributable to lack of health insurance. In January 2008, the Urban Institute, created by a blue ribbon commission appointed by President Johnson to study, among other things, health reform,

issued a report entitled, “Uninsured and Dying Because of It.” (Appendix N at 47–48). The Urban Institute concluded that nationally, 137,000 people died from 2000 through 2006 because they lacked health insurance. It reported, “Uninsured women with breast cancer, for example, have their disease diagnosed later during its development, when treatment is less effective.... Uninsured men with hypertension are more likely to go without screenings and prescribed medication and to skip recommended doctor visits, increasing the likelihood of serious harm.” *Id.* at 48. Similarly, in 2009, the American Journal of Public Health (Dec. 2009, Vol. 99, no. 12) published a report by a group of physicians—“Health Insurance and Mortality in US Adults”—that “Lack of health insurance is associated with as many as 44,789 deaths per year in the United States.” (Appendix O at 49–50).

3. **Medicaid Expansion Will Benefit Hundreds of Thousands of Low-Income Adults in Ohio**

The benefits of Medicaid expansion to hundreds of thousands of Ohioans without health insurance are also crucial.<sup>2</sup> Director Tracy Plouck of the Ohio Department of Mental Health and Addiction Services summarized clearly the transformative nature Medicaid expansion will have on the lives of low-income Ohioans on April 24, 2013. She testified before the House Health and Human Services Subcommittee:

“**thousands of Ohioans**—people who live in our communities and struggle with tremendous challenges that if untreated, can lead to terrible outcomes for themselves and their families—**will get the help** they need to become healthy and independent, and contribute to the workforce. This can help **transform lives**.” (Appendix P at 52) (Emphasis added).

Director Plouck told the heartrending story of Tony, who was suffering from delusions, alcohol and marijuana. She said:

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<sup>2</sup> As the briefs filed by Respondents and other amici will show, the Medicaid expansion will also benefit millions of other Ohioans, will benefit businesses in Ohio and will benefit Ohio government.

Tony's "behavior caused absenteeism from work, resulting in not only job loss, but also lack of access to health insurance. Tony recognizes that he needs help. However, when he contacts the local ADAMH board for services, he learns that because he's uninsured he can only access safety net services depending on availability. At this point, there is a long waiting list for treatment, as many resources are focused on meeting crisis-related needs.... On **January 1, 2014, Tony will be eligible for Medicaid.** His clinical services will be funded through that program [instead of state and local resources], **getting him the treatment he needs in a timely way.**" (*Id.* at 53, Emphasis added).

Director Plouck noted that there are "**thousands of stories like this one.**" *Id.* (Emphasis added).

Veterans will benefit greatly from the Medicaid expansion. In a 2010 study of nearly 129,000 nonelderly veterans, the Urban Institute found that there were 52,000 uninsured veterans in Ohio and estimated that "nearly half of uninsured veterans would qualify for expanded Medicaid coverage." (Appendix Q at 54) (Emphasis added). The study added, "Compared with insured veterans, uninsured veterans have served more recently, are younger, have lower levels of education, are less likely to be married, and are less connected to the labor force." *Id.* The study also noted that VA health care applied to service-related disabilities and not general health care, and "more than half of veterans reporting only VA care could qualify for Medicaid to supplement their VA care under the expansion...." *Id.* at 58.

Individuals with disabilities will also benefit greatly from the Medicaid expansion, among other ways by expanding access to community-based supports that are crucial for these individuals to remain in their own homes and not end up needlessly segregated in institutions, a form of discrimination prohibited by the Americans with Disabilities Act. See *Olmstead v. L. C.*, 527 U.S. 581 (1999). For individuals with disabilities who do not have access to health care coverage, they will not have needed supports, leading to worsening conditions, possible institutionalization, or even death. The National Association on Mental Illness (NAMI), for instance, concluded that "Expanding Medicaid will help people get mental health services before

their symptoms get worse and they experience debilitating, or even tragic, outcomes.” (Appendix R at 61). As one example of the tragic results, NAMI noted that there are 38,000 suicides every year in the United States. *Id.* The report said that six out of ten people in the United States living with serious mental illness have no access to mental health care (*Id.* at 60), and the Medicaid expansion will start to correct that.

NAMI noted, by way of contrast with the uninsured, the story of Sharon’s son (children of low-income families are eligible for Medicaid), who greatly benefited from Medicaid services:

“Three years ago my son was in a very dark place. He was flunking out of school and living a life of seclusion. He holed up in his room while the rest of the family walked on eggshells. Today, he is a completely different person. It took three years of counseling and finding the right medication for his bipolar disorder, but we did it. If we didn’t have Medicaid, I don’t know where we would be right now.” *Id.* at 60.

Similarly, the Judge David L. Bazelon Center for Mental Health Law reported in 2012 that Medicaid expansion “presents an opportunity for people with mental illness to fully benefit” from community-based services. (Appendix S at 63).

The homeless will also benefit. There is a high prevalence of mental illness, substance abuse and physical disorders among the 1.2 million citizens in this country who are homeless, and most of these individuals will be eligible for Medicaid under the expansion (Appendix T at 65). Both the Center for Health Care Strategies and the National Health Care for the Homeless Council have reported that Medicaid expansion would improve health outcomes, reduce bankruptcies caused by medical debts and reduce homelessness (Appendix T at 64–65 and Appendix U at 69).

Adult females of child-bearing age without children will also benefit greatly from the Medicaid expansion, as will any children they have. Although Medicaid covers low-income

adult females who are pregnant, it does not cover such females before they become pregnant, and that gap in coverage can be crucial. The Urban Institute reported there were 113,000 uninsured females in Ohio between the ages of 19–44 with incomes below 100% of Federal Poverty Level and concluded, “Medicaid expansion has the potential to lead to better health in the pre-conception period to increased spacing between births, and to improved birth outcomes and health of newborns.” (Appendix V at 71-72). It added that increased coverage “should increase the extent to which their physical and mental health needs are addressed, and reduce the financial burdens they experience associated with health care.” *Id.* at 71. It concluded that “exclusively monetary calculations ignore the potential human financial and productivity benefits associated with improved access to affordable health care for the millions of low-income adults who lack health insurance coverage and their families.” *Id.*

An often overlooked and unpopular population that will benefit from Medicaid expansion are prisoners released back into the community—who will typically have no health insurance or otherwise have access to health care. The Pew Charitable Trusts reported “it will help address the generally poor health of ex-offenders, reduce medical costs and possibly keep them from sliding back into crime.” (Appendix W at 73). Pew quoted Faye S. Taxman, Ph.D., a professor in the Criminology, Law and Society Program, George Mason University, “We now have a golden opportunity to develop and implement quality interventions to both improve health outcomes for this population and also reduce the rate of criminal activity.” *Id.*

The Kaiser Commission on Medicaid and the Uninsured summarized very clearly the beneficial effect of Medicaid expansion in its August 2013 report, “What is Medicaid’s Impact on Access to Care, Health Outcomes, and Quality of Care?”:

Health insurance coverage is associated with better health outcomes for adults. It is also associated with having a regular source of care and with greater and

more appropriate use of health services. These factors, in turn, improve the likelihood of disease screening and early detection, the management of chronic illness, and effective treatment of acute conditions such as traumatic brain injury and heart attacks. The ultimate result is improved health outcomes.

(Appendix X at 74). Looking at states that had previously expanded Medicaid, the Commission noted that “having Medicaid led to a 30% reduction in the rate of positive screens for depression,” and the Commission agreed that expanded Medicaid coverage was associated with “significant reductions” in adult mortality. *Id.* at 75.

4. **Relators Indicate that They Want to “Vindicate the Public Interest,” But the Public Interest Strongly Argues for This Court to Deny the Requested Writ**

Relators acknowledge the Court’s discretion in determining whether to grant a writ of mandamus (pp. 29 & 35 of their Brief) and argue that the Court should exercise its discretion and grant the requested writ (pp. 35–38 of their Brief). However, Relators have only an ideological interest, and indeed they recognize at ¶105 of their Complaint that they have “no rights or obligations peculiar” in this litigation. At 27 of their Brief, Relators suggest they bring this action “to vindicate the public interest.” The public interest calls for the Medicaid expansion to go into effect on January 1, 2014.

For the period covered by the action of the Controlling Board, the federal government will pay for 100% of the costs of the Medicaid expansion. 42 U.S.C. §1396d(y)(1) provides that the “Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, shall be equal to—(A) 100 percent for calendar quarters in 2014, 2015, and 2016 ...” (Emphasis added), decreasing after 2016 to the level of 90% in 2020 and remaining at that level for each year thereafter.

The suggestion by Relators of increased net costs to Ohio as a result of the expansion is a hoax. The March 2013 study by the authoritative Health Policy Institute of Ohio (HPIO) was a coordinated effort among the HPIO, The Ohio State University, Regional Economic Models, Inc., the Health Foundation of Greater Cincinnati, the Mt. Sinai Health Care Foundation and the George Gund Foundation (Appendix B at 25)—Expanding Medicaid in Ohio Analysis of Likely Effects.” (Appendix F at 32–33). That study found that the Medicaid expansion would: (1) “increase Ohio’s Medicaid costs between \$2.4 billion and \$2.5 billion over the nine-year period from state fiscal year (SFY) 2014 to SFY 2022,” even though for six of those years under 42 U.S.C. §1396d(y)(1) the federal government’s share would be less than 100%; (2) “allow \$1.6 billion in state budget savings during SFY2014–2022”; (3) “generate between \$2.7 billion and \$2.8 billion in state revenue during FY2014–2022”; and (d) “create between \$1.8 and \$1.9 billion in state budget gains over the nine-year period” *Id.* at 32. (Emphasis added).

Relators speculate at p. 31 that some unspecified number of low-income Ohioans with current health insurance would switch to Medicaid and then subsequently not be able to switch back to private insurance if this Court were to block the expansion. Of course, that speculation ignores the fact that a ruling in Relators’ favor would harm the 360,000 Ohioans without health insurance who are under 100% of the Federal Poverty Level (Appendix B at 25). Moreover, even if Relators’ speculation were true that some other Ohioans would switch from private insurance to Medicaid, the solution to the “dilemma” posed by Relators would simply be to uphold the expansion—thereby keeping both the currently insured and uninsured protected. In fact, the HPIO study says that Medicaid expansion would reduce the number of uninsured Ohio residents by more than 450,000 (Appendix F at 33), and there is absolutely no evidence of potential harm to individuals currently covered by insurance.

Relators disregard the harm suffered by the 360,000 Ohioans (Appendix B) who are below 100% of the Federal Poverty Level and have no health insurance. As indicated above, the HPIO studies were the product—not of speculation by individuals with an ax to grind against expansion—but of the extensive nonpartisan work of the HPIO and those working in collaboration with the HPIO. Medicaid expansion is the only hope for regular medical care for individual adults in Ohio below the Federal Poverty Level, the kind of medical care most of us take for granted.

Relators argue for granting a writ blocking the expansion because the Medicaid expansion “implicates the manner in which health care coverage will be provided to as many as 366,000 Ohioans” (p. 37 of Relators’ Brief). Yes, the Medicaid expansion will help preserve their lives, and this of course is a compelling reason to allow the Medicaid expansion to go forward.

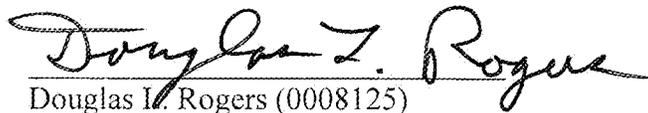
While using these Ohioans as a reason for blocking the Medicaid expansion, Relators do not even mention the harm that these Ohioans would suffer if Relators were successful in blocking the Medicaid expansion on January 1. As set forth in B2 above, the harm that would occur from blocking the Medicaid expansion is clear. So are the benefits clear from Medicaid expansion, as set forth in B3 above, and as shown by the experience in other states which previously expanded Medicaid to cover low-income adults without minor children. Three distinguished Harvard professors, including the chair of the Section on Health Services and Policy Research in the Department of Medicine at Harvard University, concluded: “State Medicaid expansions to cover low-income adults were significantly associated with reduced mortality as well as improved coverage, access to care, and self-reported health” (Appendix Y at 76) (Emphasis added). See also, Families USA, “Dying For Coverage The Deadly

Consequences of Being Uninsured (June 2012) (Appendix Z at 77–80) (“Uninsured Americans are sicker and die earlier than those who have insurance.” *Id.* at 80). The great public interest calls for protecting the lives of the 360,000 Ohioans without any health insurance who are under 100% of the Federal Poverty Level by denying the request for a writ of mandamus.

### C. CONCLUSION

Relators have no right to a writ of mandamus. If Relators were successful in blocking this Medicaid expansion, Relators would have ripped away the lifeline of Medicaid expansion for low-income Ohioans for an undetermined period of time, during which time an unknown number of low-income adults in Ohio would deteriorate emotionally and physically—and some would die—due to the lack of health care. Amici respectfully request that this Court dismiss Relators’ Complaint.

Respectfully submitted,



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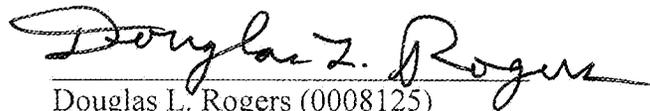
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**CERTIFICATE OF SERVICE**

I certify that a copy of the foregoing was sent by ordinary U.S. Mail to the following counsel on this 22<sup>nd</sup> day of November, 2013:

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**APPENDIX A:**  
**ADDITIONAL STATEMENTS OF INTEREST**

1. American Cancer Society Cancer Action Network (ACS CAN) believes that providing hundreds of thousands of hard-working, low-income Ohio residents access to adequate and affordable healthcare, through the state Medicaid program, is one of the most effective ways to prevent and detect cancer early, treat cancer effectively and bolster the quality of life for patients enduring cancer treatment. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN is supported by 24,000 volunteers in the state of Ohio, working on behalf of the estimated 66,000 Ohioans that are diagnosed with cancer this year.
2. National Health Law Program (see pages 23-24).
3. Policy Matters Ohio is a nonprofit, nonpartisan institute with offices in Cleveland and Columbus that does research and advocates for policies that will make for a more prosperous, equitable, sustainable and inclusive Ohio. Our research has found that Medicaid expansion would be a significant benefit to the people of Ohio and a major step toward fulfilling the above goals.
4. Disability Rights Ohio is a non-profit corporation with a mission to advocate for the human, civil, and legal rights of people with disabilities in Ohio. Disability Rights Ohio provides legal advocacy and rights protection to a wide range of people with disabilities. This includes assisting individuals with problems such as abuse, neglect, discrimination, access to assistive technology, special education, housing, employment, community integration, voting and rights protection issues with the juvenile and criminal justice systems. Access to health care is a critical issue for people with disabilities, and Disability Rights Ohio has much experience as an advocate on this issue.
5. People First of Ohio is a statewide organization whose leaders are people with disabilities. The organization helps to set up local chapters of self-advocates, who in turn help others with disabilities become self-advocates. Self-advocates represent themselves by talking about their needs and rights with people in their communities. Self-advocates make sure that people with disabilities have the right to do what they want in their lives, are responsible for their own choices, and have the right to live and do things in the community like other citizens. The statewide organization works with state legislators and builds relationships with other advocacy groups and state agencies. These relationships promote better interaction among people who make decisions in the communities and the state. People First believes that all people with disabilities should be treated as equal, and be able to speak up for what they want by serving as leaders and working together as a team with all members of the community. People First believes Medicaid expansion will help to enable people with disabilities to live in their communities like other citizens.

5. The Arc of Ohio is a statewide membership association made up of people with intellectual and developmental disabilities, their families, friends, interested citizens and professionals in the disability field. Together with our individual members and local chapters, we represent more than 330,000 Ohioans with intellectual and developmental disabilities and their families. Ohio law recognizes The Arc of Ohio as the organization to represent families in Legislative decisions. The mission of The Arc of Ohio is to advocate for human rights, personal dignity and community participation of individuals with intellectual and developmental disabilities, through legislative and social action, information and education, local chapter support and family involvement. The Arc of Ohio is proud to join this amicus brief as part of its advocacy work on behalf of individuals with developmental disabilities, their families and friends.

6. The Center for Community Solutions, originally founded in 1913 in Cleveland, Ohio, is a 501c(3) non-profit organization with extensive experience in data driven non-partisan public policy analysis to improve health, social, and economic conditions. For the past two decades, CCS has increasingly focused on the pivotal role of state government in the federal system of managing and financing health and social services, including work with two groundbreaking blue ribbon Medicaid reform commissions, The Ohio Commission to Reform Medicaid (2003-04) and Ohio Medicaid Administrative Study Council (2005-06).

7. The Ohio Empowerment Coalition, Inc. is an independent and autonomous organization represents the collective voices of consumers receiving or seeking mental health services in all 88 counties as well as Consumer Operated Services and advocacy groups. Our goals are: 1. To inspire hope and promote recovery; 2. To foster inclusive statewide outreach and involvement; 3. To facilitate empowerment and create leadership; 4. To advocate for consumer voice and social justice; and 5. To provide educational opportunities. Medicaid expansion is a crucial issue for individuals with mental illness.

8. Toledo Area Jobs with Justice & Interfaith Worker Justice Coalition supports the opportunity to provide thousands of currently uninsured people with lifesaving health coverage through Medicaid; we want families across the state to have the security of knowing they have access to the medical care and treatments they otherwise could not afford.

9. Toledo/Lucas County CareNet is a 10-year-old nonprofit organization that operates as a partnership among the City of Toledo, Mercy, ProMedica, the Academy of Medicine of Toledo/Lucas County, the Lucas County Commissioners, the Neighborhood Health Association, St. Luke's Hospital, the Toledo Area Regional Transport Authority, the Dental Center of Northwest Ohio, the Toledo-Lucas County Health Department, the United Way of Greater Toledo, and the University of Toledo Medical Center, and provides access to coordinated healthcare services for low-income (up to 200 % of the Federal Poverty Level) uninsured residents of Lucas County who do not qualify for Medicare or Medicaid.

#### APPENDIX A

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## 10 Reasons the Medicaid Expansion Helps to Address Health Disparities

Prepared By: Deborah Reid  
August 21, 2012

1. **People of color are more likely to be low-income, uninsured, and without access to employer-based health insurance.** The Medicaid Expansion, which will cover individuals with incomes below 133% of the federal poverty level (FPL) (\$30,657 for a family of four), will disproportionately benefit people of color. Nearly 70% of nonelderly whites hold employer-based insurance compared to only 40% of Hispanics, 48% of African Americans, and 43% of Native Americans/Native Alaskans.<sup>1</sup> In 2008, racial and ethnic minorities comprised about 52% of all uninsured childless adults with incomes at or below 133% FPL.<sup>2</sup>
2. **The Medicaid Expansion includes coverage for mental health and substance use services.** Serious mental disorders (SMD) are especially prevalent among adults living in poverty (9.1%) compared to wealthier individuals (3.7 %).<sup>3</sup>
3. **The Medicaid Expansion will help to improve a glaring health disparity that particularly impacts low-income men of color.** African American men have a higher incidence of and death rate from prostate cancer than white men. Uninsured and low-income men of color with incomes below 200% FPL are especially at risk for undetected and untreated prostate cancer.<sup>4</sup> Expanded Medicaid coverage will provide low-income men with incomes below 133% FPL access to primary care providers, cancer screenings, and patient education.<sup>5</sup>
4. **The Medicaid Expansion will improve birth outcomes for uninsured women. Lack of insurance is linked to delayed prenatal care, increased infant mortality, and complicated deliveries.**<sup>6</sup> In 2010, 29.2% of American Indians and Alaska Natives (AI/AN) were uninsured. AI/AN infants have a 60% higher death rate than their non-Hispanic white counterparts.<sup>7</sup> The Expansion would provide maternity and newborn care as well as preventive and wellness services.<sup>8</sup>
5. **The Medicaid Expansion will help women of color with HIV/AIDS with early access to treatment.** Latinas represented 19% of new AIDS diagnoses among all Latinos (men and women combined) in 2010 and Black women represented 34% of new diagnoses among Blacks.<sup>9</sup> The Expansion extends coverage to individuals below 133% FPL without first requiring them to be unable to work.<sup>10</sup>
6. **The Medicaid Expansion will help more than 1.2 million low-income, uninsured older (55 – 64 year old) women.** Fourteen percent of near- elderly women are uninsured including a significant number of Latinas and African Americans. They have higher health needs than younger women including the health effects of menopause, a greater likelihood of pre-existing conditions, and heightened risk for cancers.<sup>11</sup>
7. **The Medicaid Expansion would help to improve access to a usual source of care.** A UCLA study found that moderate and low-income uninsured populations are only about half as likely as their insured counterparts to have visited a physician in the past year. For example, in Tampa, Florida 47% of the moderate and low-income uninsured had no physician visit compared to 24% of those with insurance.<sup>12</sup>
8. **The Medicaid Expansion will help women of color access care. Currently, many women of color avoid doctors' visits due to the cost.**<sup>13</sup> The Medicaid Expansion provides cost-sharing protections for all Medicaid enrollees that minimize the cost barrier. Family planning and other preventive health services such as screening for diabetes, obesity and depression - all linked to chronic conditions - will be available without cost-sharing.

[www.healthlaw.org](http://www.healthlaw.org)

APPENDIX A

9. **The Medicaid Expansion would result in improvements in coverage and care to people in rural areas.** Rural dwellers tend to experience higher rates of poverty than their urban counterparts.<sup>14</sup> Twenty-four percent of people living in rural counties that are not adjacent to urban counties are uninsured. Moreover, racial and ethnic minorities in rural counties are three times more likely to live in poverty than whites in rural areas.<sup>15</sup>
10. **The Medicaid Expansion supports the viability of safety-net and public hospitals that provide care to underserved communities.** Ninety percent of patients served in medical home programs offered by safety-net hospitals are racial and ethnic minorities, including significant numbers of low-income and uninsured populations. Medical home programs focus on chronic disease management, coordinating access to specialty care services, reducing overutilization of emergency departments, and providing culturally competent and linguistically appropriate care.<sup>16</sup>

<sup>1</sup> AM. C. PHYSICIANS, RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE – UPDATED 2010 5 (2010).

<sup>2</sup> Kaiser Family Foundation, *Expanding Medicaid Under Health Reform: A Look At Childless Adults At or Below 133% of Poverty* (April 2010), available at <http://tinyurl.com/9x5any9>.

<sup>3</sup> DEP'T. OF HEALTH & HUM. SERV., SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., MENTAL HEALTH, UNITED STATES 2010 10 (2010).

<sup>4</sup> David Miller, M.D., M.P.H., et al, *Prostate Cancer Severity Among Low-Income Uninsured Men* (May 9, 2009), available at <http://tinyurl.com/8uaguuu>.

<sup>5</sup> See Ina Wu, M.D., *Disparities in Prostate Cancer in African American Men: What Primary Care Physicians Can Do*, 79 CLEVELAND CLINIC J. OF MED. 313 (May 2012).

<sup>6</sup> Institute of Medicine, *Uninsurance Facts & Figures* (2004), available at <http://tinyurl.com/c9ynxhb>.

<sup>7</sup> Dep't. of Health & Hum. Serv., Office of Minority Health, *Infant Mortality/SIDS Data and Statistics* (July 5, 2012), available at <http://tinyurl.com/cp8m6id>.

<sup>8</sup> ACA, Pub. L. No. 111-148, § 1302 (2010).

<sup>9</sup> Kaiser Fam. Found., *HIV/AIDS Policy – Fact Sheet: Latinos and HIV/AIDS* (July 2012), available at <http://tinyurl.com/7ps3esd>.

<sup>10</sup> National Health Law Program, *10 Reasons Medicaid Expansion Benefits Women Living with HIV* (Aug. 17, 2012), available at <http://www.healthlaw.org>.

<sup>11</sup> LDI Health Economist, *Near-Elderly Women and A New Medicaid Disparity* (June 2012), available at <http://tinyurl.com/98nc52e>.

<sup>12</sup> E. Richard Brown, et al., *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000), available at <http://tinyurl.com/9ky9otd>.

<sup>13</sup> AM. C. PHYSICIANS, RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE—UPDATED 2010 (2010).

<sup>14</sup> Rural Assistance Center, *Medicaid Frequently Asked Questions* (May 21, 2012), available at <http://tinyurl.com/8g629a6>.

<sup>15</sup> KAISER FAM. FOUND., HEALTH INSURANCE COVERAGE IN RURAL AMERICA (Sept. 2003).

<sup>16</sup> Sari Siegel-Spieler, Ph.D. et al, National Public Health and Hospital Institute, *Medical Homes at Safety Net Hospitals Improve Access to Culturally Competent Care and Reduce ER Overcrowding* (June 26, 2010), available at <http://tinyurl.com/d2ilfdc>.

# Expanding Medicaid in Ohio

## Impact on Ohioans earning less than 100 percent FPL

If Ohio does not move forward with Medicaid expansion, thousands of Ohioans with incomes up to 100 percent of the Federal Poverty Level (FPL) (\$23,550 for a family of four) will have no subsidized coverage assistance (see figures on next page). Those earning more than 100 percent FPL would be eligible for federal subsidies on health insurance exchanges. To the right are county-level projections for uninsured adults (19-64 years old) without dependent children who earn less than 100 percent of FPL.

**Without a Medicaid expansion, substantial number of Ohioans, including more than 370,000 adults without dependent children by 2017, are projected to have no access to subsidized health coverage and will likely be uninsured.**

Other Ohioans left without subsidized coverage include parents with incomes between 90 percent and 100 percent FPL.

### Ohio Medicaid Expansion Study

This material was created as part of Ohio Medicaid Expansion Study, a partnership between the Health Policy Institute of Ohio, the Ohio State University, Regional Economic Models, Inc. and the Urban Institute. The research is funded by the Health Foundation of Greater Cincinnati, the Mt. Sinai Health Care Foundation and the George Gund Foundation. To view all publications and material from the Study, visit <http://bit.ly/Yb1qxi>

County	Total uninsured childless adults in 2014 below 100 percent FPL	Total uninsured childless adults in 2017 below 100 percent FPL
Adams	1,523	1,561
Allen	3,522	2,611
Ashland	1,352	1,387
Ashtabula	4,075	4,178
Athens	2,181	2,236
Auglaize	977	1,002
Belmont	2,407	2,467
Brown	1,745	1,789
Butler	10,327	10,587
Carroll	978	1,003
Champaign	1,121	1,149
Clark	5,942	6,092
Clermont	5,272	5,405
Clinton	1,810	1,855
Columbiana	3,616	3,707
Coshocton	1,471	1,508
Crawford	1,823	1,869
Cuyahoga	44,698	45,825
Darke	1,284	1,317
DeFiance	1,232	1,263
Delaware	1,883	1,930
Erie	2,532	2,595
Fairfield	4,494	4,607
Fayette	1,262	1,294
Franklin	40,652	41,677
Fulton	1,024	1,056
Gallia	1,464	1,500
Geauga	969	993
Greene	3,638	3,729
Guernsey	1,778	1,824
Hamilton	24,451	25,068
Hancock	1,994	2,044
Hardin	993	1,018
Harrison	568	583
Henry	736	755
Highland	1,935	1,984
Hocking	1,241	1,272
Holmes	1,329	1,352
Huron	2,052	2,103
Jackson	1,616	1,658
Jefferson	2,554	2,618
Knox	1,892	1,940
Lake	4,368	4,478
Lawrence	2,662	2,750

County	Total uninsured childless adults in 2014 below 100 percent FPL	Total uninsured childless adults in 2017 below 100 percent FPL
Licking	4,922	5,046
Logan	1,705	1,748
Lorain	8,599	8,815
Lucas	17,792	18,249
Madison	1,177	1,207
Mahoning	8,790	9,011
Marion	2,551	2,615
Medina	2,714	2,782
Meigs	1,140	1,169
Mercer	1,801	1,821
Miami	2,186	2,241
Monroe	538	551
Montgomery	17,846	18,296
Morgan	585	600
Morrow	1,192	1,222
Muskingum	3,906	4,005
Noble	412	422
Ottawa	947	975
Paulding	617	632
Perry	1,647	1,688
Pickaway	1,793	1,838
Pike	1,589	1,629
Portage	3,698	3,791
Preble	1,282	1,314
Putnam	597	612
Richland	4,454	4,566
Ross	3,540	3,629
Sandusky	1,692	1,734
Scioto	3,650	3,742
Seneca	1,937	1,986
Shelby	1,262	1,294
Stark	11,892	12,181
Summit	16,411	16,825
Trumbull	7,149	7,329
Tuscarawas	2,786	2,857
Union	1,075	1,102
VanWert	799	819
Vinton	689	706
Warren	2,605	2,671
Washington	1,690	1,733
Wayne	2,757	2,827
Williams	1,236	1,267
Wood	2,213	2,269
Wyandot	489	502

Source: OSU 2013

Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
233 North Michigan Avenue, Suite 600  
Chicago, Illinois 60601-5519



October 10, 2013

John McCarthy, Director  
Ohio Department of Medicaid  
P.O. Box 182709  
50 West Town Street, Suite 400  
Columbus, Ohio 43218

RE: TN OH-13-0018

Dear Mr. McCarthy:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal # OH-13-0018 MAGI-Based Eligibility Group-Medicaid coverage for individuals  
with incomes below 133% of the FPL, effective January 1, 2014.

Please contact Christine Davidson, of my staff, at (312) 886-3642 or [christine.davidson@cms.hhs.gov](mailto:christine.davidson@cms.hhs.gov)  
if you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Verlon Johnson".

Verlon Johnson  
Associate Regional Administrator  
Division of Medicaid and Children's Health Operations

Enclosure

cc: Debbie Saxe, ODJFS  
Lynne Lyon, ODJFS  
Andy Jones, ODJFS  
Becky Jackson, ODJFS

APPENDIX C

**Medicaid State Plan Eligibility: Summary Page (CMS 179)**

State/Territory name: **Ohio**  
 Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

OH-13-0018

**Proposed Effective Date**

01/01/2014 (mm/dd/yyyy)

**Federal Statute/Regulation Citation**

Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act

**Federal Budget Impact**

	Federal Fiscal Year	Amount
First Year	2014	\$ 1048700000.00
Second Year	2015	\$ 1999500000.00

Subject of Amendment  
 Adult Group

**Governor's Office Review**

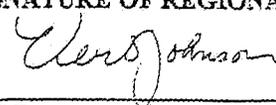
- Governor's office reported no comment
- Comments of Governor's office received

Describe:

- No reply received within 45 days of submittal
  - Other, as specified
- Describe:  
 The state Medicaid Director is the Governor's designee.

**Signature of State Agency Official**

Submitted By: **John Mccarthy**  
 Date Submitted: **Sep 26, 2013**

<b>DATE RECEIVED:</b> 9/26/2013	<b>DATE APPROVED:</b> 10/10/2013
PLAN APPROVED - ONE COPY ATTACHED	
<b>EFFECTIVE DATE OF APPROVED MATERIAL:</b> 01/01/2014	<b>SIGNATURE OF REGIONAL OFFICIAL:</b> 
<b>TYPED NAME</b> Verlon Johnson	<b>TITLE</b> Associate Regional Administrator



# Medicaid Eligibility

OMB Control Number 0938-1148  
OMB Expiration date: 10/31/2014

**Eligibility Groups - Mandatory Coverage**  
**Adult Group** S32

1902(a)(10)(A)(i)(VIII)  
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

Yes  No

**Adult Group - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.**

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Have attained age 19 but not age 65.

Are not pregnant.

Are not entitled to or enrolled for Part A or B Medicare benefits.

Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

Have household income at or below 133% FPL.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

There is no resource test for this eligibility group.

Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

Under age 19, or

A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

Under age 20

Under age 21

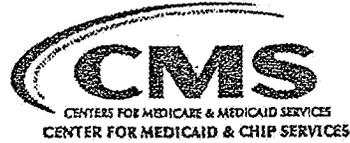
**Presumptive Eligibility**

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes  No

APPENDIX C

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop: S2-26-12  
Baltimore, Maryland 21244-1850



JUN 13 2013

The Honorable Maggie Hassan  
Governor of New Hampshire  
Concord, NH 03301

Dear Governor Hassan:

Thanks to the Affordable Care Act, in 2014, Americans will have access to new marketplaces that will provide high quality insurance choices. Additionally, the law provides states with the authority to expand their Medicaid programs up to 133 percent of the federal poverty level. Starting in 2014, all of the costs of covering newly eligible adults will be paid for by the federal government for the first three years and the federal government will cover at least 90 percent of these costs in the years thereafter. CMS encourages all states to fully expand their Medicaid programs and take advantage of the generous federal matching funds to cover more of their residents. As we have previously indicated, there is no deadline for you to tell CMS your plans on the Medicaid eligibility expansion. Should New Hampshire choose to expand Medicaid coverage, the state may drop that expanded coverage at any time, without financial penalty from the federal government.

I look forward to working with you toward our ultimate goal of ensuring that every American has access to affordable, high quality health care. Please do not hesitate to contact me if you have any further questions or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read "Cindy Mann". The signature is fluid and cursive.

Cindy Mann  
Director

cc: Richard McGreal, Associate Regional Administrator, CMS Boston Regional Office

APPENDIX D



# Moving Forward with Health Reform

Center on  
Budget  
and Policy  
Priorities

July 29, 2010

Note: Since the release of this report, the Affordable Care Act changed the law to include Social Security benefits as income when calculating Medicaid eligibility. For updated information on calculating household income both for Medicaid and for health reform's premium tax credits, see <http://www.healthreformbeyondthebasics.org/category/issues/determining-household-income/>

## Health Reform Expands Medicaid Coverage For People with Disabilities

By Judith Solomon

The new health reform law will cover over 30 million uninsured Americans, including 16 million low-income adults and children through Medicaid. A substantial number of the people who will gain Medicaid coverage under health reform have disabilities or chronic health care conditions. Medicaid is particularly well-suited for these individuals because it is both affordable and comprehensive, covering a number of services that they need (such as case management and mental health care and therapy services) but that private insurance typically does not cover or covers only to a limited extent.

### How Does Eligibility for Medicaid Change in 2014?

In most states today, to be eligible for Medicaid, an adult must not only have a low income but must also be 65 or over, pregnant, a parent living with a dependent child, or a person with a disability that meets Supplemental Security Income (SSI) disability standards. Generally, adults who are not in one of these categories are not eligible for Medicaid regardless of how poor they are.

The health reform law establishes a new group of individuals that all states must cover through Medicaid beginning in 2014. It includes people with incomes below 133 percent of the poverty line (about \$14,000 for an individual) who are: under 65 years of age, not pregnant, not enrolled in or entitled to Medicare, and not already required to be covered by Medicaid under federal law. These individuals' assets will not be considered in determining their eligibility, so small bank accounts or life insurance policies will not disqualify them from receiving Medicaid.

In addition, for most people, health reform will change the rules regarding how income is counted in determining their Medicaid eligibility. The new rules will be aligned with the rules for determining eligibility for the new subsidies that the health reform law provides to help low- and moderate-income people purchase coverage through the new health insurance exchanges. This change will make more people with disabilities eligible for Medicaid.

### How Will These Changes Benefit People With Serious Disabilities?

Currently, a person whose disability meets SSI disability standards can generally qualify for Medicaid. People who receive SSI disability benefits qualify for Medicaid automatically in most states. However, low-income people with disabilities who have other income or assets, such as a pension or a small savings account, may be ineligible because their income or assets put them modestly over the Medicaid limits.

Health reform will allow many of these individuals to qualify by increasing Medicaid's income eligibility limit to 133 percent of the poverty line and by not applying an asset test to the new eligibility group.

APPENDIX E

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The Center on Budget and Policy Priorities  
820 First Street, NE, Suite 510, Washington, DC 20002  
Ph: 202-408-1080 | Fax: 202-408-1056 | center@cbpp.org

1

## What About People Receiving Social Security Disability Benefits?

Unlike SSI disability benefits, which are based on financial need, Social Security disability benefits (often called Title II benefits) are based on an individual's work history and earnings. People receiving these benefits do not become eligible for Medicare until the 25<sup>th</sup> month after they begin receiving Social Security; during this waiting period, many beneficiaries with modest incomes are uninsured. Despite their limited incomes, they often do *not* qualify for Medicaid, since in most states, Medicaid eligibility for people with disabilities ends at or below the poverty line.

Under health reform, many of these uninsured individuals will become eligible for Medicaid because of the increase in Medicaid's eligibility limit to 133 percent of the poverty line and because of a change in how their Social Security benefits are considered in determining eligibility. Under the new rules, Social Security benefits will *not* count as income for most beneficiaries with modest incomes for the purposes of determining Medicaid eligibility. Many low-income people with disabilities who are within the two-year waiting period for Medicare thus will be able to qualify for Medicaid coverage during that period.

This change will rectify one of the most indefensible gaps in health coverage in the United States — the lack of coverage for many severely disabled low-income people during the first years of their disability. After 24 months, when these individuals become eligible for *Medicare*, they will no longer qualify for Medicaid. (Many will be eligible at that point for assistance with Medicare cost-sharing that is provided through state Medicaid programs.)

## Will These Changes Help Other People with Disabilities or Chronic Conditions?

A substantial number of low-income people under 65 who are not the parents of a dependent child have disabilities or chronic conditions that are not severe enough to meet the standards for receiving SSI or Social Security disability benefits. They consequently are often uninsured. These people are left out of Medicaid because they do not qualify as elderly, disabled, or parents.

But under health reform, people no longer have to fit into such a category to qualify for Medicaid. Low-income individuals with disabilities and chronic conditions that do not meet the SSI disability standards will become eligible for the program as long as their income is below 133 percent of the poverty line.

## How Do These Changes Apply to Adults Who Need Long-Term Services and Supports?

The health reform law makes no change in the eligibility rules that apply to these individuals. Adults seeking Medicaid coverage for long-term services and supports, including care in a nursing home or home- and community-based services, must meet current Medicaid rules for determining financial eligibility, including any asset test their state uses. They also must be at least 65 or meet the standards for having a disability.

## How Will Medicaid Benefits for Newly Eligible People with Disabilities Be Financed?

The federal government will pay most of the cost. During the first three years that these provisions are in effect (2014-2016), it will pay 100 percent of the Medicaid costs of covering people with disabilities whom the health reform law makes newly eligible for Medicaid. Federal support will then phase down modestly over the following several years, so that for 2020 and all subsequent years, the federal government will pay 90 percent of the costs of covering these individuals.

# Expanding Medicaid in Ohio

## Analysis of likely effects

Ohio policymakers must decide whether to expand Medicaid eligibility to 138 percent of the federal poverty level (FPL). Such an expansion would be supported by unusually generous federal funding levels that have already been set aside for that purpose under the Patient Protection and Affordable Care Act (ACA).

To help lawmakers understand the advantages and disadvantages of such an expansion, we estimated expansion's cost and coverage effects using two different approaches:

- **The Urban Institute's Health Insurance Policy Simulation Model (HIPSM)** is a "microsimulation" model, like the models used by the Congressional Budget Office and the U.S. Treasury Department to project the effects of federal legislation. These models begin with the characteristics of each resident, as shown by national survey data. They then apply the health economics literature and empirical observations to show how behavior would respond to specific policy changes, such as a Medicaid expansion in Ohio.
- **Ohio State University (OSU)** developed an actuarial-type model to estimate the effects of Medicaid expansion in Ohio. This model analyzes groups of Ohio residents that share characteristics like income, age, and current eligibility for coverage. It then applies specific assumptions, such as those involving participation levels, to predict each group's responses to policy changes, such as the Medicaid expansion. In effect, this model moves from the "top down," unlike a microsimulation, which moves from the "bottom up."

Using the results from these two methods, we estimated the impact on the state's economy as a whole, employing a model of Ohio's economy developed by Regional Economic Modeling, Inc. (REMI). We found that both HIPSM and OSU's models, combined with REMI, project the same basic results from a Medicaid expansion:

1. Expanding Medicaid eligibility would **increase Ohio's Medicaid costs between \$2.4 billion and \$2.5 billion over the nine-year period** from state fiscal year (SFY) 2014 to SFY 2022.
2. Expanding Medicaid eligibility would allow **\$1.6 billion in state budget savings** during SFY 2014-2022. With an expansion, certain categories of current Medicaid spending would qualify for higher federal matching rates, letting the state reduce its spending. Also, non-Medicaid spending on health care for the poor and near-poor uninsured would be replaced by federal Medicaid dollars, allowing a reduction in state general fund spending.
3. Expanding Medicaid would **generate between \$2.7 billion and \$2.8 billion in state revenue** during FY 2014-2022. More people would enroll in Medicaid managed care, which would increase the state's managed care sales and insurance tax revenue. More people would receive Medicaid coverage of prescription drugs, which would increase the state's receipt of rebates from drug manufacturers. Finally, more federal money would buy health care from Ohio providers and insurers, who in turn would buy other goods and services, much of it from other Ohio businesses. The resulting economic activity would generate sales and income tax revenue for the state.
4. On balance, a Medicaid expansion would **create between \$1.8 and \$1.9 billion in net state budget gains** over the nine-year period covered by our estimates. These resources could be redirected to other priorities, including tax relief or education funding. For the next three and one-half biennia, a Medicaid expansion would generate significant state budget gains each year. Starting in SFY 2021, the expansion's costs and fiscal gains would roughly balance, with the state continuing to experience small, ongoing net fiscal benefits. Table ES-1 shows these effects, year by year.

### APPENDIX F

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<http://bit.ly/ZLGk5p>

table ES1. Overall impact of Medicaid expansion on the state budget, under UI and OSU estimates (millions)

Fiscal year	Increased state costs from more Medicaid enrollment		Savings (spend-down adults, BCCP inpatient prison costs, retroactive and other pre-MCO costs)	Revenue (taxes on managed care plans, general revenue, drug rebates)		Net state fiscal gains	
	UI	OSU		UI	OSU	UI	OSU
2014	\$13	\$22	\$53	\$59	\$82	\$99	\$113
2015	\$30	\$48	\$110	\$172	\$212	\$252	\$274
2016	\$38	\$57	\$185	\$240	\$256	\$387	\$384
2017	\$147	\$156	\$191	\$307	\$298	\$351	\$333
2018	\$284	\$278	\$196	\$345	\$317	\$257	\$235
2019	\$347	\$333	\$203	\$374	\$338	\$230	\$208
2020	\$472	\$439	\$208	\$406	\$364	\$142	\$133
2021	\$580	\$529	\$215	\$431	\$383	\$66	\$69
2022	\$617	\$559	\$226	\$458	\$404	\$67	\$71
<b>Total:</b>	<b>\$2,529</b>	<b>\$2,421</b>	<b>\$1,587</b>	<b>\$2,792</b>	<b>\$2,654</b>	<b>\$1,851</b>	<b>\$1,820</b>

Source: OSU 2013; Urban Institute HIPSM 2012; REMI 2013. Note: "UI" refers to Urban Institute estimates. Table does not include possible savings from obtaining higher federal matching funds for people with incomes below 138percent FPL who currently receive Medicaid through Transitional Medical Assistance, the family planning waiver, pregnancy-based coverage, or Medicaid Buy-In for Working People with Disabilities. It also does not include savings from existing state spending, other than on inpatient care for prisoners, that goes to provide medical services to the uninsured. Columns may not total due to rounding.

5. **A Medicaid expansion would affect Ohio residents in other ways.** For example, during the final year we analyze, a Medicaid expansion would:

- Reduce the number of uninsured Ohio residents by more than 450,000
- Create more than 27,000 Ohio jobs
- Reduce health care costs for Ohio employers and residents by \$285 million and \$1.1 billion, respectively
- Generate significant savings and revenues for Ohio counties

6. **Without a Medicaid expansion, the ACA would create small, net budget losses** during the SFY 2014-2022 period as a whole. Policymakers would need to add the Medicaid expansion to the remainder of the ACA for the federal legislation to yield net state budget gains.

Our results differ from those released at an earlier stage of this project, for several reasons:

- We included the effects of federally-subsidized coverage in the health insurance exchange serving Ohio residents on state tax revenue;
- We analyzed the impact of Medicaid expansion on retroactive Medicaid claims; and
- We supplemented the Urban Institute's microsimulation estimates with estimates from OSU's model, providing a range of projections rather than a single point estimate of many effects of Medicaid expansion.

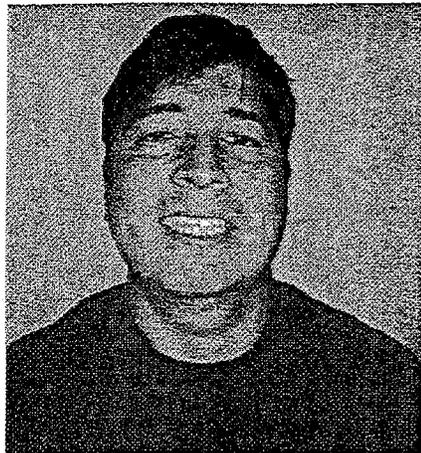
A later stage of this project will quantify the impact of Medicaid expansion on regions within Ohio as well certain counties.

The Ohio Medicaid Expansion Study is a partnership between the following organizations:



January 2013

## FACES OF THE MEDICAID EXPANSION: How Obtaining Medicaid Coverage Impacts Low-Income Adults



### APPENDIX G

EXECUTIVE SUMMARY

The Affordable Care Act (ACA) seeks to fill the longstanding gap in Medicaid coverage for low-income adults by expanding eligibility to a minimum floor of 138% of the federal poverty level (FPL), or \$24,344 for a family of 3 in 2012. However, the Supreme Court ruling on the ACA effectively made implementation of the Medicaid expansion a state choice. If a state does not expand Medicaid, poor uninsured adults in that state will not gain access to a new affordable coverage option and will likely remain uninsured. To provide insight into the potential impacts of expanding Medicaid, this report highlights the experiences of adults in California, Connecticut, Minnesota, and the District of Columbia, which all have already expanded Medicaid to adults. Based on focus groups and interviews with previously uninsured adults who recently gained Medicaid coverage in these states, it examines the personal impacts gaining coverage had on individuals' health, finances, employment, and overall well-being.

Findings

The participants covered by Medicaid expansions are a diverse group of adults with varying health needs who face ongoing financial struggles. Participants range in age and race, have differing family circumstances, and include a mix of healthy individuals and those with serious and chronic illnesses and physical and mental health needs. Nearly all participants said they are struggling financially. They worry about paying bills and affording basic necessities like groceries. While many have recently gained employment or are working part-time, others have lost jobs and are looking for work. While most are living in their own homes or rented apartments, some have moved in with friends, parents, or other relatives. A few are receiving assistance from other social service programs.

"It's very stressful wondering where your next pay is going to come from; how you're going to pay [bills]...even for those that...have some type of income, it's still a struggle. It's like you're getting paid but then you still don't have enough money to survive."  
Angelette, California

While uninsured, participants could not afford to obtain needed care, resulting in significant negative impacts on their health and contributing to major stress and worry in their lives. Participants used words such as "scared," "uneasy," "insecure," and "nervous" to describe what it felt like to be uninsured. While uninsured, they were often unable to afford needed care or medications. Some participants described instances when they got sick or injured and had to decide whether their conditions were serious enough to seek care and face the large bills associated with that care. Participants described waiting until conditions worsened or became unbearable before seeking care and frequently relying on the emergency room when they did seek care, which resulted in large bills they could not pay. Moreover, a number said they were unable to obtain recommended follow-up care after receiving emergency treatment.

"Being uninsured felt horrible [be]cause you basically have to be on your death bed before you go to the doctor's because you can't afford it." Cindy, California

"My head was bleeding and...the ambulance came and I was supposed to go to the hospital, but I didn't...because I didn't have insurance." Susan, Minnesota

"I broke my hand and...I went to the emergency room...but I didn't go for follow-up care because I didn't have insurance. [I] basically worked with a broken hand for two months... I should have had a doctor take care of [this] for me, but I didn't because I didn't have insurance." John L., Minnesota

Obtaining Medicaid coverage enabled participants to access care for unmet needs and preventive care, which had positive impacts on their health and other areas of their lives. Gaining Medicaid coverage provided a significant sense of relief to participants. They used words like “secure” and “grateful” to describe what it feels like to have Medicaid coverage. Many noted that obtaining coverage enabled them to get medications and needed care they had gone without while uninsured. In addition, many obtained a physical after enrolling in coverage and are hoping to follow up with other preventive services, such as colonoscopies and well-woman exams. For some participants, physicals led to the diagnosis of conditions such as diabetes, asthma, and anemia, for which they are now receiving care. Participants also noted that having Medicaid enables them to seek care from a physician early rather than waiting until conditions worsen or using the emergency room. Many participants have established a relationship with a primary care provider and say they appreciate having a doctor who can get to know them and coordinate their care. Participants also emphasized that, by enabling them to get their health needs met, obtaining Medicaid coverage facilitated their ability to take charge of their lives and focus on other goals and priorities, such as employment.

“You would put it off and put it off and put it off until you were almost at death’s door and you had to go to the emergency room, you didn’t have a choice. But...now...you can go to your doctor, you can discuss what you need and then you can go get your prescriptions and fortunately everything is good.” Matthew, DC

“It makes me feel better because I have...family history and I have to make sure that I’m staying on top of things...So being able to have a doctor where I can say...I need to get this checked out because I might be at risk for this...makes me feel a lot better.” Alfreda, California

“That’s a huge support system for me to...look for a job and do all these other things...[be]cause I have the health coverage I have and that’s a security.” Low-income adult, Connecticut

Nearly all participants said that states should expand Medicaid and cited broad positive impacts of expanding coverage. When told that other states will decide whether to expand Medicaid, participants urged state leaders to consider the financial burden of being uninsured on families and noted that coverage would provide their residents financial security so that they do not have to make difficult decisions between paying for medical care and taking care of their families. Others stressed that as hard-working, tax-paying citizens, they deserved some help during difficult economic times. They noted that being able to manage their health enables them to better focus on work and obtaining jobs, which has long-term economic benefits for the state. Several participants acknowledged states’ concerns about the costs, especially given already tight state budgets, but noted that there were already high costs associated with providing care to uninsured people in the emergency room.

### Conclusion

These findings suggest that the Medicaid expansion would have significant positive impacts on individuals’ personal lives by enabling them to obtain needed care, providing financial protection from the cost of care, and alleviating a significant source of stress and worry. They further show that providing Medicaid coverage enables individuals to utilize physicians for care rather than delaying care and ultimately turning to the emergency room. As such, coverage can facilitate earlier diagnosis and treatment of conditions and improved care management, which may help lead to less serious and costly health problems in the long run. Moreover, by helping individuals get their health under control, providing Medicaid coverage supports their ability to take charge of their lives and focus on other priorities and goals, including employment. This broad array of potential personal impacts is another factor to be considered as states weigh going forward with the Medicaid expansion.

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# The Evolving Role of Prevention in Health Care

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## Contributions of the U.S. Preventive Services Task Force

### Background Article

By Steven H. Woolf, M.D., M.P.H.<sup>a</sup> and David Atkins, M.D., M.P.H.<sup>b</sup>

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## Introduction

Many of the leading causes of death and disability in the United States can be prevented (1). *Primary prevention* can prevent or arrest the disease process in its earliest stages by promoting healthier lifestyles or immunizing against infectious disease. *Secondary prevention*, by detecting and treating asymptomatic risk factors or early asymptomatic disease, can substantially reduce subsequent morbidity or mortality. The clinician plays a pivotal role in both primary and secondary prevention. Health professionals deliver vaccinations, screen for modifiable risk factors such as high blood pressure and high cholesterol, counsel patients about smoking and other behavioral risk factors, provide screening tests for early detection of cancer and other chronic conditions, and advise patients about the benefits and risks of preventive therapies such as postmenopausal hormone replacement therapy.

The health care landscape has changed dramatically in the 17 years since the U.S. Preventive Services Task Force (USPSTF/Task Force) was first established in 1984 to provide advice about prevention for health professionals. Prevention has become an integral component of primary health care (2). Delivery of clinical preventive services such as immunizations, mammograms, and cholesterol screening has risen steadily over the past two decades (3). Roughly 90% of employers now

REPORT

**47**  
million

# THE UNINSURED A PRIMER

October 2013

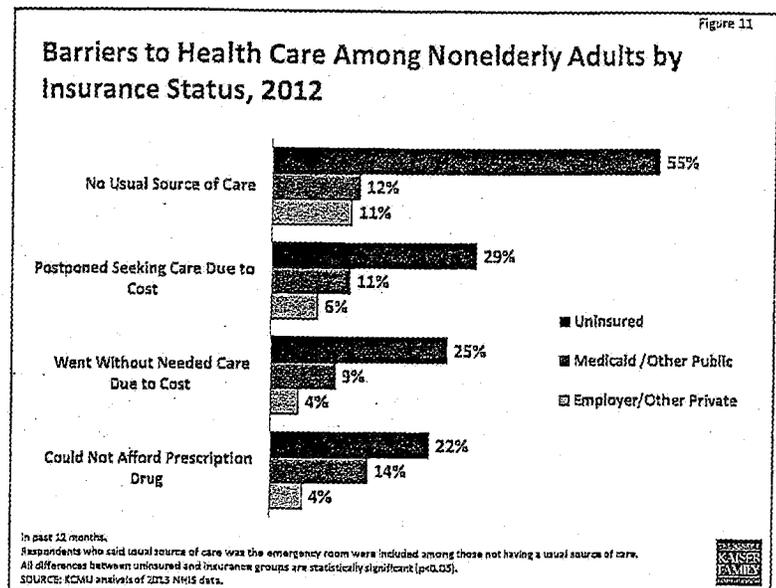
Key Facts about Health Insurance on  
the Eve of Health Reform



## HOW DOES LACK OF INSURANCE AFFECT ACCESS TO HEALTH CARE?

Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy people are. Uninsured adults are far more likely than those with insurance to postpone or forgo health care altogether. The consequences can be severe, particularly when preventable conditions go undetected.

**Uninsured people are far more likely than those with insurance to report problems getting needed medical care.** One-quarter of adults without coverage (25%) say that they went without care in the past year because of its cost compared to 4% of adults with private coverage. Part of the reason for poor access among the uninsured is that more than half of uninsured adults (55%) do not have a regular place to go when they are sick or need medical advice (Figure 11).

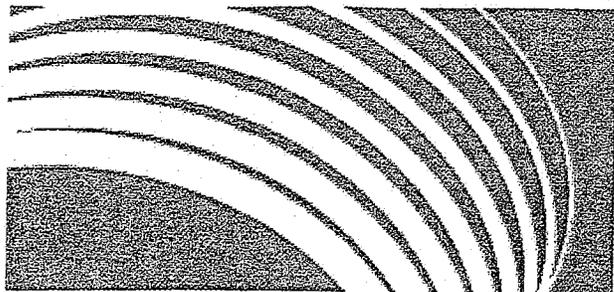


**Access to health care has eroded over time for many.** Rising health care costs have made health care less affordable over time, particularly for uninsured people. Between 2000 and 2010, the differences in access to care between those with and without coverage widened.<sup>43</sup>

**Uninsured people are less likely than those with coverage to receive timely preventive care.** Silent health problems, such as hypertension and diabetes, often go undetected without routine check-ups. Uninsured nonelderly adults, compared to those with coverage, are far less likely to have had regular preventive care, including blood pressure, cholesterol checks, and cancer screenings.<sup>44,45</sup> Uninsured patients are also less likely to receive necessary follow-up screenings after abnormal cancer tests.<sup>46</sup> Consequently, uninsured patients have increased risk being diagnosed in later stages of diseases, including cancer, and have higher mortality rates than those with insurance.<sup>47,48,49</sup>

**Anticipating high medical bills, many uninsured people are not able to follow recommended treatments.** Nearly a quarter of uninsured adults say they did not take a prescribed drug in the past year because they could not afford it.<sup>50</sup> Regardless of a person's insurance coverage, those injured or newly diagnosed with a chronic condition receive similar follow-up care plans; however, people without health coverage are less likely than those with coverage to actually obtain all the services that are recommended.<sup>51</sup>

**Because people without health coverage are less likely than those with insurance to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and experience declines in their overall health.** When they are hospitalized, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.<sup>52,53,54,55</sup>



# U.S. Preventive Services Task Force

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You Are Here: U.S. Preventive Services Task Force > Newsroom > U.S. Preventive Services Task Force Issues New Cervical Cancer Screening Recommendations

## U.S. Preventive Services Task Force Issues New Cervical Cancer Screening Recommendations

### *Evidence shows that cervical cancer screening is effective*

Washington, D.C. – On March 15, *Annals of Internal Medicine* published online the U.S. Preventive Services Task Force's (Task Force's) final recommendation statement on cervical cancer screening, which includes several specific recommendations.

After a systematic review of the available evidence, posting a draft recommendation statement for public comment, and considering the comments it received, the Task Force concluded:

- Women aged 21 to 65 should be screened with cytology (commonly known as Pap smear) every 3 years. As an alternative, women aged 30 to 65 who want to be screened less frequently may choose the combination of cytology and human papillomavirus (HPV) testing every 5 years, which offers similar benefits to cytology only. This is an A recommendation.
- The Task Force recommends against screening women who have had a hysterectomy with removal of the cervix, women younger than age 21, or women older than age 65 who previously have been adequately screened. These are D recommendations. Evidence showed that the expected harms (such as unnecessary procedures, false positives, and possible problems with future pregnancies) of screening these populations outweighed the potential benefits.
- The Task Force also recommends against cervical cancer screening using HPV testing in women younger than age 30. This is a D recommendation. Evidence showed that the expected harms (such as unnecessary procedures, false positives, and possible problems with future pregnancies) of this screening in this group outweighed the potential benefits.

These recommendations apply to women, regardless of sexual history, who have a cervix and show no signs or symptoms of cervical cancer. These recommendations do not apply to women who are already at high risk for cancer, such as those who have been diagnosed with a high-grade precancerous cervical lesion or who have weakened immune systems.

Since the implementation of widespread cervical cancer screening, there has been a dramatic reduction in cervical cancer deaths in the United States. "About half of women diagnosed with this disease have never had a Pap smear or have not been adequately screened. Therefore, it is important for clinicians and health care systems to get women into screenings who have never been screened, or who have not been screened in the last 5 years," said Task Force member Wanda Nicholson, M.D., M.P.H., M.B.A.

The public comment period is an important part of the Task Force's process in developing its final recommendations. In addition to allowing the Task Force to clarify language on the harms of screening too frequently and in women younger than age 21, it provided an opportunity to review two studies related to HPV testing that were published after the Task Force's initial systematic review. After reviewing this new evidence, the Task Force determined that co-testing with HPV and cytology (Pap smear) every 5 years for women aged 30 and older offers comparable benefits to cytology-only screening at 3-year intervals.

"This public comment period was crucial in giving the Task Force the time needed to review this new evidence, so that our recommendations reflect the most up-to-date science, in this case related to HPV co-testing," said Task Force Chair Virginia Moyer, M.D., M.P.H.

These recommendations are in line with the recommendations and screening guidelines of other organizations, such as the soon to be released joint guidelines from the American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology, as well as guidelines from the American Congress of Obstetricians and Gynecologists.

ISSUE BRIEF  
March 2013

## How can early treatment of serious mental illness improve lives and save money?

### Takeaways:

- Serious mental illness incurs huge personal, social, and economic costs – including an estimated \$193 billion a year in lost earnings alone.
- Early detection and intervention can help reduce the toll of serious mental illness.
- Although some states are moving toward early detection and intervention models, the U.S. health care system currently is not equipped to make such programs widely available.

### Overview

Treatment of serious mental illness is currently not well-integrated into the U.S. health care system. The enactment of mental health parity, which puts mental health coverage on par with medical coverage, and the inclusion of mental health coverage in the essential health benefit package established under the Affordable Care Act (ACA) are steps in the right direction. However, critical gaps remain, leaving many people at risk for lifelong disabilities, hospitalization, jail time, or suicide. Early detection and treatment of serious mental illnesses works, but more must be done to implement this model throughout the health care and social service systems.

### DISEASE BURDEN

An estimated 4 million young people will develop a severe mental disorder, such as schizophrenia or bipolar affective disorder.<sup>2</sup> In addition to its enormous economic costs, serious mental illness has devastating effects on young people and their families. Seventy-five percent of people with schizophrenia go on to develop a disability and fewer than 25 percent are gainfully employed.<sup>3</sup> Twenty-five percent of U.S. hospital admissions and disability payments are for people with severe mental disorders.<sup>4</sup>

Seventy percent of youth in the juvenile justice system suffer from mental health disorders; 27 percent of cases are so severe that functional ability is seriously impaired.<sup>5</sup> People with serious mental illness die eight years earlier than the general population,<sup>6</sup> and an estimated 10 percent to 15 percent of people who suffer from severe mental illness commit suicide.<sup>7</sup>

### EARLY INTERVENTION

Under our health care system, we wait until young people with severe mental illness are very sick and have suffered serious consequences before treating them. Young people who show early signs of mental disorders often do not receive treatment because of stigma or because they lack information about where to go. Yet delayed treatment is associated with incomplete and prolonged recovery.



## **Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents**

Downloaded from <http://aidsinfo.nih.gov/guidelines> on 11/3/2013

Visit the AIDS*info* website to access the most up-to-date guideline.

Register for e-mail notification of guideline updates at <http://aidsinfo.nih.gov/e-news>.

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APPENDIX L

## **Introduction** (Last updated February 12, 2013; last reviewed February 12, 2013)

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Antiretroviral therapy (ART) for the treatment of HIV infection has improved steadily since the advent of potent combination therapy in 1996. New drugs that offer new mechanisms of action, improvements in potency and activity even against multidrug-resistant viruses, dosing convenience, and tolerability have been approved. ART has dramatically reduced HIV-associated morbidity and mortality and has transformed HIV disease into a chronic, manageable condition. In addition, effective treatment of HIV-infected individuals with ART is highly effective at preventing transmission to sexual partners.<sup>1</sup> However, less than one-third of HIV-infected individuals in the United States have suppressed viral loads,<sup>2</sup> which is mostly a result of undiagnosed HIV infection and failure to link or retain diagnosed patients in care. Despite remarkable improvements in HIV treatment and prevention, economic and social barriers that result in continued morbidity, mortality, and new HIV infections persist.

The Department of Health and Human Services (HHS) Panel on Antiretroviral Guidelines for Adults and Adolescents (the Panel) is a working group of the Office of AIDS Research Advisory Council (OARAC). The primary goal of the Panel is to provide HIV care practitioners with recommendations based on current knowledge of antiretroviral (ARV) drugs used to treat adults and adolescents with HIV infection in the United States. The Panel reviews new evidence and updates recommendations in these guidelines when needed. The Panel's primary areas of attention have included baseline assessment, treatment goals, indications for initiation of ART, choice of the initial regimen for ART-naïve patients, drugs or combinations to avoid, management of adverse effects and drug interactions, management of treatment failure, and special ART-related considerations in specific patient populations. For recommendations related to pre-exposure HIV prophylaxis (PrEP) for HIV-uninfected persons, please refer to recommendations from the Centers for Disease Control and Prevention (CDC).<sup>3,4</sup>

These guidelines generally represent the state of knowledge regarding the use of ARV agents. However, because the science of HIV evolves rapidly, the availability of new agents and new clinical data may change therapeutic options and preferences. Information included in these guidelines may not be consistent with approved labeling for the particular products or indications in question, and the use of the terms "safe" and "effective" may not be synonymous with the Food and Drug Administration (FDA)-defined legal standards for product approval. The Panel frequently updates the guidelines (current and archived versions of the guidelines are available on the *AIDSinfo* website at <http://www.aidsinfo.nih.gov>). However, the guidelines cannot always be updated apace with the rapid evolution of new data in the field of HIV and cannot offer guidance on care for all patients. Clinicians should exercise clinical judgment in management decisions tailored to unique patient circumstances.

The Panel recognizes the importance of clinical research in generating evidence to address unanswered questions related to the optimal safety and efficacy of ART. The Panel encourages both the development of protocols and patient participation in well-designed, Institutional Review Board (IRB)-approved clinical trials.

### APPENDIX L

# Initiating Antiretroviral Therapy in Treatment-Naive Patients (Last updated February 12, 2013; last reviewed February 12, 2013)

## Panel's Recommendations

- Antiretroviral therapy (ART) is recommended for all HIV-infected individuals to reduce the risk of disease progression. The strength and evidence for this recommendation vary by pretreatment CD4 cell count: CD4 count <350 cells/mm<sup>3</sup> (AI); CD4 count 350–500 cells/mm<sup>3</sup> (AII); CD4 count >500 cells/mm<sup>3</sup> (BIII).
- ART also is recommended for HIV-infected individuals for the prevention of transmission of HIV. The strength and evidence for this recommendation vary by transmission risks: perinatal transmission (AI); heterosexual transmission (AI); other transmission risk groups (AIII).
- Patients starting ART should be willing and able to commit to treatment and understand the benefits and risks of therapy and the importance of adherence (AIII). Patients may choose to postpone therapy, and providers, on a case-by-case basis, may elect to defer therapy on the basis of clinical and/or psychosocial factors.

*Rating of Recommendations: A = Strong; B = Moderate; C = Optional*

*Rating of Evidence: I = Data from randomized controlled trials; II = Data from well-designed nonrandomized trials or observational cohort studies with long-term clinical outcomes; III = Expert opinion*

## Introduction

Without treatment, the vast majority of HIV-infected individuals will eventually develop progressive immunosuppression (as evident by CD4 count depletion), leading to AIDS-defining illnesses and premature death. The primary goal of antiretroviral therapy (ART) is to prevent HIV-associated morbidity and mortality. This goal is best accomplished by using effective ART to maximally inhibit HIV replication so that plasma HIV RNA levels (viral load) remain below that detectable by commercially available assays. Durable viral suppression improves immune function and quality of life, lowers the risk of both AIDS-defining and non-AIDS-defining complications, and prolongs life.

Furthermore, high plasma HIV RNA is a major risk factor for HIV transmission and use of effective ART can reduce viremia and transmission of HIV to sexual partners.<sup>1,2</sup> Modelling studies suggest that the expanded use of ART may result in lower incidence and, eventually, prevalence of HIV on a community or population level.<sup>3</sup> Thus, a secondary goal of ART is to reduce the risk of HIV transmission.

Historically, HIV-infected individuals have presented for care with low CD4 counts,<sup>4</sup> but increasingly there have been concerted efforts to both increase testing of at-risk patients and to link HIV-infected patients to medical care soon after HIV diagnosis (and before they have advanced HIV diseases). For those with high CD4 cell counts, whose short-term risk for death may be low,<sup>5</sup> the recommendation to initiate ART is based on growing evidence that untreated HIV infection or uncontrolled viremia is associated with development of non-AIDS-defining diseases, including cardiovascular disease (CVD), kidney disease, liver disease, neurologic complications, and malignancies. Furthermore, newer ART regimens are more effective, more convenient, and better tolerated than regimens used in the past.

Regardless of CD4 count, the decision to initiate ART should always include consideration of any co-morbid conditions, the willingness and readiness of the patient to initiate therapy, and the availability of resources. In settings where resources are not available to initiate ART in all patients, treatment should be prioritized for patients with the lowest CD4 counts and those with the following clinical conditions: pregnancy, CD4 count <200 cells/mm<sup>3</sup>, or history of an AIDS-defining illness, including HIV-associated dementia, HIV-associated nephropathy (HIVAN), hepatitis B virus (HBV), and acute HIV infection.

## APPENDIX L

REPORT BRIEF • FEBRUARY 2009

## AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE

When policy makers and researchers consider potential solutions to the crisis of uninsurance in the United States, the question of whether health insurance matters to health is often an issue. This question is far more than an academic concern. It is crucial that U.S. health care policy be informed with current and valid evidence on the consequences of uninsurance for health care and health outcomes, especially for the 45.7 million individuals without health insurance.

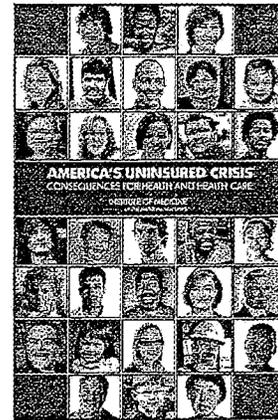
From 2001 to 2004, the Institute of Medicine (IOM) issued six reports, which concluded that being uninsured was hazardous to people's health and recommended that the nation move quickly to implement a strategy to achieve health insurance coverage for all.

The goal of this report is to inform the health reform policy debate—in 2009—with an up-to-date assessment of the research evidence. This report addresses three key questions: (1) What are the dynamics driving downward trends in health insurance coverage? (2) Is being uninsured harmful to the health of children and adults? (3) Are insured people affected by high rates of uninsurance in their communities?

### CAUGHT IN A DOWNWARD SPIRAL: HEALTH INSURANCE COVERAGE IS DECLINING AND WILL CONTINUE TO DECLINE

A number of ominous signs point to a continuing decline in health insurance coverage in the United States. Health care costs and insurance premiums are growing substantially faster than the economy and family incomes. Rising health care costs and a severely weakened economy threaten not only employer-sponsored insurance, the cornerstone of private health coverage in the United States, but also threaten recent expansions in public coverage. There is no evidence to suggest that the trends driving loss of insurance coverage will reverse without concerted action.

Overall, fewer workers, particularly those with lower wages, are offered employer-sponsored insurance, and fewer among the workers that are offered such insurance can afford the premiums. Moreover, employment has shifted away from industries with traditionally high rates of coverage, such as manufacturing, to service jobs, such as wholesale and retail trades, with historically lower rates of coverage. In some industries, employers have relied more heavily on jobs without health benefits, including part-time and shorter-term



A number of ominous signs point to a continuing decline in health insurance coverage in the United States.

APPENDIX M



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45

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**RECENT RESEARCH FINDINGS ON THE HARMFUL EFFECTS OF  
UNINSURANCE FOR ADULTS WITH SELECTED ACUTE CONDITIONS  
AND CHRONIC DISEASE**

Condition	Findings
Acute ischemic stroke	Uninsured adults are more likely than insured adults to suffer extremely poor outcomes, including neurological impairment, intracerebral hemorrhage, and death.
Cancer	Uninsured adults are more likely than insured adults to be diagnosed at an advanced stage of cancer, especially if effective treatments are available and the condition can be detected early by screening (e.g., breast or colorectal cancer) or by clinical assessment of symptoms (e.g., melanoma, bladder cancer).
Congestive heart failure	Uninsured adults are at greater risk of death than insured adults.
Diabetes	Uninsured adults have significantly worse glycemic control than insured adults.
Heart attack	Uninsured adults are more likely than insured adults to die after heart attack.
Hospital inpatients with serious acute conditions	Uninsured adults are at greater risk than insured adults of higher mortality in hospital and for at least 2 years after admission.
Hypertension	Uninsured adults are less likely than insured adults to be aware of hypertension and, if hypertensive, more likely to have inadequate blood pressure control.
Serious injury or trauma	After an unintentional injury, uninsured adults are less likely than insured adults to fully recover and more likely to report subsequent declines in health status. Uninsured adults in severe automobile accidents have a substantially higher mortality rate.

When children acquire health insurance they receive more timely diagnosis of serious health conditions, experience fewer avoidable hospitalizations, have improved asthma outcomes, and miss fewer days of school.

Research shows children benefit considerably from health insurance. When children acquire health insurance:

- They are more likely to have access to a usual source of care; well-child care and immunizations to prevent future illness and monitor developmental milestones; prescription medications; appropriate care for asthma; and basic dental services.
- Serious childhood health problems are more likely to be identified early, and children with special health care needs are more likely to have access to specialists.
- They receive more timely diagnosis of serious health conditions, experience fewer avoidable hospitalizations, have improved asthma outcomes, and miss fewer days of school.

# Uninsured and Dying Because of It:

Updating the Institute  
of Medicine Analysis  
on the Impact of  
Uninsurance on Mortality

Shari Dorn

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January 2008



**Urban Institute**

## Summary

The absence of health insurance creates a range of consequences, including lower quality of life, increased morbidity and mortality, and higher financial burdens. This paper focuses on just one aspect of this harm—namely, greater risk of death—and seeks to illustrate its general order of magnitude.

In 2002, the Institute of Medicine (IOM) estimated that 18,000 Americans died in 2000 because they were uninsured. Since then, the number of uninsured has grown. Based on the IOM's methodology and subsequent Census Bureau estimates of insurance coverage, 137,000 people died from 2000 through 2006 because they lacked health insurance, including 22,000 people in 2006.

Much subsequent research has continued to confirm the link between insurance and mortality risk described by IOM. In fact, subsequent studies and analysis suggest that, if anything, the IOM methodology may underestimate the number of deaths that result from a lack of insurance coverage.

More broadly, these estimates should be viewed as reasonable indicators of the general magnitude of excess mortality that results from lack of insurance, not as precise "body counts." The true number of deaths resulting from uninsurance may be somewhat higher or lower than the estimates in this paper, but that number is surely significant.

## The IOM methodology

The IOM's 2002 report, *Care Without Coverage: Too Little, Too Late*, described the considerable research showing that the absence of health coverage impedes access to care, which ultimately increases the risk of illness and death. Uninsured women with breast cancer, for example, have their disease diagnosed later during its development, when treatment is less effective (Ayanian et al. 1993; Roetzheim et al. 1999, 2000; Lee-Feldstein et al. 2000; cited in IOM 2002). Uninsured men with hypertension are more likely to go without screenings and prescribed medication and to skip recommended doctor visits, increasing the likelihood of serious harm (Ayanian et al. 2000; Keeler et al. 1985; Huttin, Moeller, and Stafford 2000; Fish-Parcham 2001; cited in IOM 2002).

As part of the IOM report, the authors sought to estimate the total number of deaths resulting from uninsurance. They began developing this estimate with two long-term, longitudinal studies observing the relationship between insurance status and death rates. One used 1971–87 data on 25- to 74-year-olds from the National Health and Nutrition Examination Survey (Franks, Clancy, and Gold 1993). The other used Current Population Survey (CPS) data on 25- to 64-year-olds from 1982 to 1986. (Sorlie et al. 1994). Although the two

study populations differed, as did the potentially confounding characteristics for which the researchers controlled, both studies yielded estimates attributing to uninsurance an overall increase of 25 percent in mortality risk for working-age adults.

The IOM study combined this research result with information on the numbers of deaths and the percentages of people who are insured by 10-year age intervals. IOM researchers developed the following formula, which starts with the straightforward proposition that the number of total deaths in an age group is the sum of (a) deaths among insured members of that age group and (b) deaths among uninsured members of that age group.

$$DT = DI + DU \\ = (PI \cdot X) + (PU \cdot X \cdot 1.25), \text{ where}$$

*DT* = total deaths in a particular age cohort

*DI* = deaths among the insured in the age cohort

*DU* = deaths among the uninsured in the age cohort

*PI* = percentage insured in the age cohort

*PU* = percentage uninsured in the age cohort

*X* = the number of deaths that would occur if everyone in the age cohort had insurance.

Note that *DU*, or the number of deaths among the uninsured, is calculated through two steps. First, the IOM methodology ascertains the number of deaths among the uninsured as if everyone in the age cohort had insurance. That number is *X* (or the total number of deaths if everyone in the age cohort had insurance) times *PU* (or the proportion of people in the age cohort who lack insurance). Second, the number of deaths as if the uninsured had insurance is multiplied by 1.25. This yields an estimate of the actual number of deaths among the uninsured, reflecting the 25 percent higher mortality rate among the uninsured found by the above-described research.

Using the IOM's analysis of 25- to 34-year-olds to illustrate this calculation, mortality estimates from the National Center for Health Statistics (NCHS) showed that 40,548 adults age 25–34 died in 2000. Accordingly, for this age group, *DT* = 40,548.

At the time of the IOM report, data from the CPS reported that 79 percent of adults age 25–34 were insured and 21 percent were uninsured in 2000, providing the values for *PI* and *PU*, respectively. Using these figures in the above formula produces the equation:

$$40,548 = (.79 \cdot X) + (.21 \cdot 1.25 \cdot X) = (.79 \cdot X) + (.26 \cdot X) = (.79 + .26) \cdot X = 1.05 \cdot X$$

## APPENDIX N



# Health Insurance and Mortality in US Adults

Andrew P. Wilper, MD, MPH, Steffie Woolhandler, MD, MPH, Karen E. Lasser, MD, MPH, Danny McCormick, MD, MPH, David H. Bor, MD, and David U. Himmelstein, MD

The United States stands alone among industrialized nations in not providing health coverage to all of its citizens. Currently, 46 million Americans lack health coverage.<sup>1</sup> Despite repeated attempts to expand health insurance, uninsurance remains commonplace among US adults.

Health insurance facilitates access to health care services and helps protect against the high costs of catastrophic illness. Relative to the uninsured, insured Americans are more likely to obtain recommended screening and care for chronic conditions<sup>2</sup> and are less likely to suffer undiagnosed chronic conditions<sup>3</sup> or to receive substandard medical care.<sup>4</sup>

Numerous investigators have found an association between uninsurance and death.<sup>5-14</sup> The Institute of Medicine (IOM) estimated that 18 314 Americans aged between 25 and 64 years die annually because of lack of health insurance, comparable to deaths because of diabetes, stroke, or homicide in 2001 among persons aged 25 to 64 years.<sup>4</sup> The IOM estimate was largely based on a single study by Franks et al.<sup>5</sup> However, these data are now more than 20 years old; both medical therapeutics and the demography of the uninsured have changed in the interim.

We analyzed data from the Third National Health and Nutrition Examination Survey (NHANES III). NHANES III collected data on a representative sample of Americans, with vital status follow-up through 2000. Our objective was to evaluate the relationship between uninsurance and death.

## METHODS

The National Center for Health Statistics (NCHS) conducted NHANES III between 1988 and 1994. The survey combined an interview, physical examination, and laboratory testing. NHANES III employed a complex sampling design to establish national estimates of disease prevalence among the

**Objectives.** A 1993 study found a 25% higher risk of death among uninsured compared with privately insured adults. We analyzed the relationship between uninsurance and death with more recent data.

**Methods.** We conducted a survival analysis with data from the Third National Health and Nutrition Examination Survey. We analyzed participants aged 17 to 64 years to determine whether uninsurance at the time of interview predicted death.

**Results.** Among all participants, 3.1% (95% confidence interval [CI]=2.5%, 3.7%) died. The hazard ratio for mortality among the uninsured compared with the insured, with adjustment for age and gender only, was 1.80 (95% CI=1.44, 2.26). After additional adjustment for race/ethnicity, income, education, self- and physician-rated health status, body mass index, leisure exercise, smoking, and regular alcohol use, the uninsured were more likely to die (hazard ratio=1.40; 95% CI=1.06, 1.84) than those with insurance.

**Conclusions.** Uninsurance is associated with mortality. The strength of that association appears similar to that from a study that evaluated data from the mid-1980s, despite changes in medical therapeutics and the demography of the uninsured since that time. (*Am J Public Health*. 2009;99:2289-2295. doi:10.2105/AJPH.2008.157685)

noninstitutionalized civilian population in the United States.<sup>15</sup> Staff performed interviews in English and Spanish.

The NHANES III Linked Mortality File matched NHANES III records to the National Death Index (NDI). The NCHS's linkage, which uses a probabilistic matching strategy through December 31, 2000, is described elsewhere.<sup>16</sup> The NCHS perturbed the file to prevent reidentification of survey participants. Vital status was not altered in this process. The publicly released data yield survival analysis results virtually identical to the restricted-use NHANES III Linked Mortality File.<sup>17</sup>

In designing our analysis, we hewed closely to Franks's<sup>5</sup> methodology to facilitate interpretation of time trends. We analyzed data for individuals who reported no public source of health insurance at the time of the NHANES III interview. First, we excluded those aged older than 64 years, as virtually all are eligible for Medicare. Of the 33 994 individuals participating, 14 798 were aged between 17 and 64 years at the time of the interview. In keeping with earlier analyses,<sup>5-7,13</sup> we also excluded nonelderly Medicare recipients and persons covered by Medicaid and the Department of Veterans

Affairs/Civilian Health and Medical Program of the Uniformed Services military insurance (n=2023), as a substantial proportion of those individuals had poor health status as a prerequisite for coverage. Of the 12 775 participants not covered by government insurance, we excluded 663 (5.2%) who lacked information on health insurance. We excluded 974 of the remaining 12 112 who were covered by private insurance or uninsured at the time of the interview because of failure to complete the interview and physical examination. Of the remaining 11 138, we included only the 9005 with complete baseline data from both the interview and physical examination in our final analysis (Figure 1). Among those with complete insurance data, those with complete interview and examination data were both less likely to be uninsured (16.4% vs 21.6%;  $P<.001$ ) and less likely to die (3.0% vs 4.5%;  $P<.001$ ).

NHANES III staff interviewed respondents in their homes regarding demographics (including health insurance). Participants responded to questions about race, ethnicity, income, and household size. The sample design permits estimation for 3 racial/ethnic groups: non-Hispanic White, non-Hispanic Black, and

## APPENDIX O

insurance and death. For example, poor physician-rated health, poor self-rated health, and unemployment may result from medically preventable conditions. Indeed, earlier analyses suggest that the true effect of uninsurance is likely larger than that measured in multivariate models.<sup>13,40</sup> In addition, Hadley found that accounting for endogeneity bias by using an instrumental variable increases the protective effect of health insurance on mortality.<sup>40</sup>

## Conclusions

Lack of health insurance is associated with as many as 44 789 deaths per year in the United States, more than those caused by kidney disease (n=42 868).<sup>41</sup> The increased risk of death attributable to uninsurance suggests that alternative measures of access to medical care for the uninsured, such as community health centers, do not provide the protection of private health insurance. Despite widespread acknowledgment that enacting universal coverage would be life saving, doing so remains politically thorny. Now that health reform is again on the political agenda, health professionals have the opportunity to advocate universal coverage. ■

## About the Authors

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## Contributors

A.P. Wilper designed the study, planned the analysis, performed statistical analysis and data management, and interpreted the analysis. A.P. Wilper, S. Woolhandler, and D. U. Himmelstein drafted the article. K.E. Lasser, D. McCormick, and D.H. Bor performed critical revisions of the article. S. Woolhandler supervised all aspects of the study design, analysis planning, interpretation, and article preparation.

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## Human Participant Protection

The institutional review board of Cambridge Health Alliance deemed this study exempt from formal review.

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Department of Alcohol & Drug Addiction Services



Department of Mental Health

Orman Hall, ODADAS Director • John R. Kasich, Governor • Tracy J. Plouck, ODMH Director

Director Tracy J. Plouck  
Testimony before the House Health and Human Services Subcommittee  
on the Ohio Department of Mental Health and Addiction Services

April 24, 2013

Good afternoon Chair Burke, Ranking Member Cafaro and members of the Medicaid Finance Subcommittee. Today, I appreciate the opportunity to present the very first budget for the Ohio Department of Mental Health and Addiction Services (MHA).

This new state agency, if approved by the legislature, will combine the resources of the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) to integrate care and reduce state bureaucracy. In partnership with local providers and recovery boards, the new agency will touch the lives of more than 3.5 million people based on recent statistics, including:

Service / Support	Number of Clients (FY 2012)
Substance use prevention activities	2.2 million
Community substance use treatment	98,900
Community mental health treatment	233,700 adults; 124,000 youth
Six state psychiatric hospitals	7,700 admissions
Workforce development	1,100 providers trained
Therapeutic Community-Pickaway Correctional Institution	250 residents
Pharmacy Services	65 health depts., free clinics or recovery centers; 36 correctional facilities, 9 developmental centers; many other inpatient and outpatient facilities and several state agencies

Additionally, MHA regulates over 400 provider agencies, 36 consumer-operated centers, 82 private hospital psychiatric units, 674 adult care facilities and 89 adult foster homes.

This afternoon, I will outline our most significant budget proposals; highlight budget-related aspects of our agency consolidation; and update you on key initiatives currently underway.

**FY 14/15 Budget Initiatives**

***Extension of Medicaid Benefits***

The Governor's proposal to extend Medicaid benefits to adults up to 138 percent of federal poverty level is the single most important investment for individuals with mental health and addiction needs in a generation of Ohio public policy.

Through this proposal, thousands of Ohioans – people who live in our communities and struggle with tremendous challenges that if untreated, can lead to terrible outcomes for themselves and their families – will get the help they need to become healthy and independent, and contribute to the workforce. This can help transform lives.

In Ohio, the safety net system for addiction and mental health services is funded by the state and 53 local board partners. This safety net exists for a wide variety of Ohioans, including but not limited to:

- Childless adults with substance use challenges that complicate their ability to work;
- People who have experienced significant trauma in childhood but, as adults, lack health care coverage necessary to access treatment; and
- Parents who are working low-wage jobs where health care is either cost prohibitive or simply not available.

Today, these individuals are not eligible for Medicaid. Instead, their mental health and addiction services are funded 100 percent by state and local resources to the extent that resources are available. In many Ohio communities, basic behavioral health needs are left unaddressed because there is a lack of funding and system capacity. Waiting lists of weeks or months are common, leading to crisis situations for individuals and families that could have been avoided. In rural areas, people may have to travel hours to access basic services.

This safety net is fragile at best, and the need for a sustainability plan has never been greater.

Chairman Burke and Ranking Member Cafaro, I've served in my current role for more than two years. I have talked with so many parents who are grieving because their adult child – possibly a high performer in high school who represented all of the hopes that they as parents ever held – died as a result of a drug overdose or suicide because they did not have access to the right kind of help. There was no health coverage, or insufficient coverage for mental health or substance use. I've met women who were victimized by prostitution because they were addicted and had no access to treatment, although they desperately wanted help. They lost their children, their health, their confidence – and certainly any ability to hold a job.

Keep in mind that mental illness and addiction affect people of all income levels and backgrounds. Recently, a woman came to my office, desperate because her young adult son with a mental illness was threatening to kill her. She had tried to reach out for help in so many different places without success so she decided to come to the state administrative offices. I could tell you countless stories like this.

As a community volunteer, I frequently talk with concerned sisters, grandmothers or fathers from all walks of life. Someone they love is addicted to heroin or prescription drugs and the family members are calling to find out how to get them connected with treatment before it is too late. The waiting lists are often prohibitively long. In some counties, we know that there are no services available. This is something that we have the opportunity to address.

Governor Kasich's brave decision to expand Medicaid will have a direct benefit on Ohio's behavioral health system. Most uninsured Ohioans who receive services from county boards of mental health and addiction services will become eligible for Medicaid under the extension.

Once these newly eligible Ohioans are enrolled, Medicaid coverage for clinical services will free up statewide an estimated \$70 million annually in county levy and state subsidy dollars – funds previously spent on these same services but without Medicaid or any other payer source.

These funds can be spent on other recovery-oriented priorities such as housing and employment supports. Currently in most Ohio communities, there are insufficient resources to meet these basic needs, which are not part of the Medicaid benefit.

By expanding Medicaid, local communities will, over time, be able to redirect existing state subsidy and local resources (as available) to fill gaps in the local service continuum, reduce waiting lists, place a greater emphasis on wellness and prevention, and improve overall health outcomes within the community. In some cases, we will be able to treat people who have never been treated before. For example, in Washington County, which has no local levy.

Let me illustrate the difference that Medicaid coverage can make.

Tony, a 26-year old, has been suffering from delusions for a while and has been self-medicating with alcohol and marijuana. This behavior caused absenteeism from work, resulting in not only job loss, but also lack of access to health insurance. Tony recognizes that he needs help. However, when he contacts the local ADAMH board for services, he learns that because he's uninsured he can only access safety net services depending on availability. At this point, there is a long waiting list for treatment, as many resources are focused on meeting crisis-related needs. When Tony is able to access clinical services, they are paid fully from a local levy (if the county has one) or state subsidy.

On January 1, 2014, Tony will be eligible for Medicaid. His clinical services will be funded through that program, getting him the treatment he needs in a timely way. He may even be placed in a Medicaid health home, ensuring integration of services for both behavioral and physical health, enhancing the quality of his care. The funds that the board previously used for clinical treatment can now be redirected to a non-Medicaid support, such as employment assistance or housing assistance to get him out of the environment that encourages his addiction. His ability to succeed in recovery and get back to being employed is greatly enhanced. There are thousands of stories like this one.

It is noteworthy that this proposal actually builds on a major initiative from the previous budget bill that elevated the responsibility for Medicaid match within behavioral health to the state level. Boards no longer have to be concerned with meeting Medicaid obligations first. Prior to elevation of Medicaid, many board areas were seeing their entire state subsidy allocation swept into the Medicaid program. Some communities even had to dedicate local levy funds for this purpose. Today, these dollars are entirely separate, making the local responsibility for planning and providing non-Medicaid supports more clear.

I realize that the decision to extend Medicaid benefits to low-income Ohioans is difficult. However, please consider carefully the plight of Ohio individuals and families in every community in the state, who are struggling each day with these terrible circumstances.

The House changes with regard to Medicaid benefits have been well-publicized and sufficiently covered by Director Moody. However, I would be remiss if I didn't draw to your attention the stark difference in the benefit to individuals with mental illness and addiction in the Governor's budget as it relates to the House passed version. The attached one-pager documents the value of

# Uninsured Veterans and Family Members: Who Are They and Where Do They Live?

## Timely Analysis of Immediate Health Policy Issues

May 2012

Jennifer Haley and Genevieve M. Kenney

### Summary

According to the 2010 American Community Survey (ACS), one in 10 of the nation's 12.5 million nonelderly veterans reports neither having health insurance coverage nor using Veterans Affairs (VA) health care. While veterans are less likely than the rest of the nonelderly population to be uninsured, there are an estimated 1.3 million uninsured veterans nationwide. Another 0.9 million veterans use VA care, but have no other health insurance coverage. An additional 0.9 million adults and children in veterans' families are uninsured. Both uninsured veterans and their family members report significantly less access to needed health care than their counterparts with insurance coverage.

Compared with insured veterans, uninsured veterans have served more recently, are younger, have lower levels of education, are less likely to be married, and are less connected to the labor force—all of which could contribute to lower access to employer-sponsored coverage. Uninsurance among veterans ranges widely across states—from under 5 percent to over 17 percent—and state variation remains even when adjusting for veterans' demographic and

socioeconomic characteristics. States also vary in levels of uninsurance among veterans' family members.

The coverage provisions slated to be implemented under the Affordable Care Act (ACA) in 2014, could increase coverage among the U.S. population, including many uninsured veterans. We estimate that nearly half of uninsured veterans would qualify for expanded Medicaid coverage. Another 40 percent of uninsured veterans could potentially qualify for subsidized coverage through health insurance exchanges if they do not have access to affordable employer coverage. However, when we classify states according to how much progress they have made toward implementing exchanges, we find higher rates of uninsurance among veterans in those states that have thus far made the least progress; nearly 40 percent of uninsured veterans and their family members live in these states. To the extent that the ACA can achieve dramatic reductions in uninsurance among veterans and their family members, success will depend on aggressive ACA implementation and enrollment efforts nationwide.

### Introduction

There is considerable public concern over the health and well-being of the estimated 13 million nonelderly veterans living in the United States.<sup>1</sup> Through the Veterans Health Administration (VHA), the Department of Veterans Affairs (VA) operates the nation's largest health system and provides health care for many veterans through a system of medical centers, clinics, and other facilities that is recognized for its commitment to providing high-quality care and that is explicitly designed to address veterans' particular health care needs.<sup>2</sup> However, some veterans do not use VA health care services. Eligibility is based on veteran status, service-related disabilities, income level, and other factors, and even within the groups eligible for VA care,

other factors, such as their proximity to VA facilities and the cost-sharing requirements, may affect the likelihood that they seek care in the VA system.<sup>3</sup> Like other groups of nonelderly adults, the health insurance coverage of veterans depends heavily on whether the family has access to employer-sponsored insurance (ESI) and the costs of obtaining ESI. In addition, since the majority of states do not provide Medicaid coverage to nondisabled adults without dependent children, and most do not cover parents with incomes above the federal poverty level (FPL),<sup>4</sup> relatively few adults, including veterans, qualify for Medicaid.<sup>5</sup> Thus, gaps remain in veterans' coverage, as demonstrated in numerous prior studies.<sup>6</sup>

As with other groups of the uninsured,<sup>7</sup> uninsurance among veterans is

associated with reduced access to health care and lower utilization rates, and uninsured veterans seem to fare no better than other uninsured individuals in getting needed care.<sup>8</sup> For example, in prior studies, uninsured veterans were substantially less likely than veterans with insurance coverage to be able to afford a doctor visit or to have had a routine medical visit in the prior year, and they were more likely to forgo care because of costs and to lack confidence that they can obtain care they need.<sup>9</sup> These access gaps may be particularly problematic for veterans with serious health needs: In a 2010 study, more than one in five nonelderly veterans reported being in fair or poor health.<sup>10</sup>

Although the Affordable Care Act (ACA), which was passed in 2010, does

APPENDIX Q

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not change the VA or other military health care systems and is not targeted specifically at veterans, it includes a number of provisions aimed at increasing access to affordable coverage that could affect veterans and their families. The ACA expands Medicaid eligibility for individuals with incomes below 138 percent of the FPL and includes subsidies for coverage in newly established health insurance exchanges to those with incomes between 138 and 400 percent of the FPL who do not have access to affordable ESI coverage.<sup>11</sup> The ACA also includes other provisions, such as an individual requirement to have health insurance, that are expected to increase coverage. The Congressional Budget Office (CBO) projects that the ACA will expand insurance coverage for more than 30 million Americans who are currently uninsured.<sup>12</sup>

In this brief, we report new estimates of uninsurance among veterans and their family members from the 2010 ACS. We use the ACS because of its large sample size: The 2010 survey has a national public use sample of nearly 129,000 nonelderly veterans and state samples that range from 169 in the District of Columbia to 10,700 in California<sup>13</sup>

This is several times larger than the samples of nonelderly veterans available from other ongoing surveys such as the Current Population Survey Annual Social and Economic Supplement (CPS ASEC), the National Health Interview Survey (NHIS), and the Behavioral Risk Factor Surveillance Study (BRFSS).<sup>14</sup> This is the first published report to provide estimates of uninsurance among nonelderly veterans and their families both nationally and at the state level and to assess the potential for the ACA to reduce their uninsurance rates. At the national level, we examine rates of uninsurance among veterans and their families, the extent to which these groups could qualify for expanded coverage under the ACA, and their access to care and health status. At the state level, we estimate uninsurance rates for veterans and their family members, examine whether state variation in veterans' uninsurance is explained by differences

in the composition of veterans in different states, and assess how uninsurance varies across groups of states which are categorized according to their progress toward implementing health insurance exchanges under the ACA. We also include supplemental analysis of veterans reporting only VA coverage, since they could also be affected by the expanded coverage options available under the ACA; for example, they could choose to supplement their VA care with Medicaid enrollment.

## Data and Methods

**Data Source.** National estimates are derived from the 2010 ACS, an annual survey fielded by the U.S. Census Bureau. State-level estimates use pooled 2009 and 2010 samples for greater precision. Additional analysis uses the 2009 and 2010 NHIS. (The appendix provides additional details on the data and methodology.)

**Measurement of Health Insurance Coverage.** Insurance status was measured in the ACS by asking the respondent about coverage of each individual in the household by any of the following types of health insurance or health coverage plans at the time of the survey:

- a. Insurance through a current or former employer or union (of this person or another family member)
- b. Insurance purchased directly from an insurance company (by this person or another family member)
- c. Medicare, for people 65 and older, or people with certain disabilities
- d. Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability
- e. TRICARE or other military health care
- f. VA (including those who have ever used or enrolled for VA health care)
- g. Indian Health Service
- h. Any other type of health insurance or health coverage plan—specify

We classify veterans as uninsured if they report neither using VA services nor having comprehensive health insurance coverage.<sup>15</sup> Although some uninsured veterans could potentially qualify for VA health services,<sup>16</sup> the available data do not indicate how many uninsured veterans could enroll in VA coverage or live near a VA health care facility nor why they do not report using VA care. Following conventions, veterans reporting only VA coverage are considered insured; for some analyses, we examine this group separately. (Although veterans receiving VA health care receive services through the VHA, we refer to this as VA coverage to remain consistent with the term used in the ACS questionnaire.)

**Identification of Veterans and their Family Members.** Nonelderly veterans are identified as those ages 19 to 64 who had ever served on active duty but are no longer serving. In addition to identifying veterans, we identified members of veterans' families. Nonelderly members of veterans' families are those ages 0 to 64 who are not veterans but who live in a household with a 19- to-64-year-old veteran who is their spouse or biological, adoptive, or stepparent.

**Additional Analyses.** Additional tabulations using the ACS examine the demographic and socioeconomic characteristics of veterans and their family members (including the era of veterans' service and whether they have service-connected disabilities), the states in which they reside, and the progress each state has made toward developing health insurance exchanges in preparation for ACA implementation.<sup>17</sup> In order to assess the potential associations between insurance coverage and health care access among veterans and their family members, we also analyzed measures of insurance coverage, access and health status from the 2009 and 2010 NHIS.

## Results

**Number of Uninsured Veterans and Family Members.** Of the estimated 12.5 million nonelderly veterans nationwide, 1.3 million, or just over 1 in 10 (10.5

**Table 1: Number and Uninsurance Rate of Nonelderly Veterans, Veterans' Nonelderly Family Members, and U.S. Nonelderly Population, 2010**

	Total Number	Number Uninsured	Uninsurance Rate
Veterans	12,456,000	1,314,000	10.5%
Family Members of Veterans	12,793,000	948,000	7.4%
Veterans and Their Family Members Combined	25,249,000	2,262,000	9.0%
U.S. Total	265,146,000	47,346,000	17.9%

Notes: Based on the 2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). Estimates reflect additional Urban Institute adjustments for the underreporting of Medicaid/CHIP and the overreporting of private nongroup coverage (see Lynch et al. 2011). Nonelderly veterans are ages 19 to 64. Family members of veterans are defined in the appendix. Uninsurance indicates the person lacks comprehensive coverage and does not use VA health services.

percent), are uninsured and do not use VA services (Table 1).<sup>18</sup> The uninsurance rate of veterans is lower than among the nonelderly population as a whole (10.5 percent compared with 17.9 percent). In addition, an estimated 7.4 percent of veterans' nonelderly family members, or 948,000 other adults and children, lack insurance coverage. Combined, there are an estimated 2.3 million uninsured veterans and family members, constituting 4.8 percent of the nation's 47.3 million uninsured in 2010.<sup>19</sup> In addition, while a total of 2.8 million of the 12.5 million nonelderly veterans in the ACS (22.9 percent) report VA use, 893,000 use only VA care and report no other source of health insurance (Table 2).<sup>20</sup>

**Characteristics of Uninsured Veterans.** Uninsured veterans differ from insured veterans across many of the characteristics we examined (Table 2). Uninsured veterans are less likely than insured veterans to report service-related disabilities, perhaps reflecting greater eligibility for and use of VA care among those with service-connected injuries and illnesses, but fully 17.3 percent of the uninsured have either a service-related disability or a functional limitation (5.2 percent of uninsured veterans have a service-connected disability and 13.2 percent have a functional limitation).<sup>21</sup> Many uninsured veterans served at some point during the last two decades; more than 4 in 10 (43.4 percent) served most recently between September 2001 and 2010 (22.1 percent) or between August 1990 and August 2001 (21.2 percent). Uninsured veterans are also younger than insured veterans, on average: Almost half (45.5 percent) of uninsured veterans

are below age 45, compared with just 29.5 percent of insured veterans, and the uninsurance rate, or the share of veterans in each subgroup who report neither having insurance coverage nor using VA care, is lowest among the oldest group of nonelderly veterans (6.5 percent for those ages 55 to 64) and highest among the youngest group (24.4 percent for those ages 19 to 24).

While the gender and racial distribution of insured and uninsured veterans is similar, the uninsured report lower levels of education (47.3 percent have no high school diploma or are high school graduates or equivalent, compared with 30.7 percent of insured veterans), higher levels of unemployment (23.4 percent compared with 5.7 percent), and lower rates of full-time work (39.9 percent compared with 63.0 percent), and they are less likely to be married than insured veterans (41.8 percent compared with 69.0 percent). Their lower likelihood of being full-time workers and being married likely contribute to their lack of coverage, as these attributes are characterized by lower access to ESI.

**Potential Eligibility for Medicaid and Exchange Subsidies under the ACA.** We also examined potential eligibility for Medicaid and subsidized coverage through health insurance exchanges under the ACA, using a definition of income that is consistent with available information on what will be used when the law is implemented: Nearly half of uninsured veterans (48.8 percent) have income levels below 138 percent of the FPL and thus would be eligible for expanded Medicaid under the ACA. This is in striking contrast to the low rates of eligibility for comprehensive

Medicaid coverage under existing rules. Although more than 600,000 uninsured veterans have family incomes below 138 percent of the FPL, just one in ten (10.0 percent) uninsured veterans appear eligible for Medicaid under current law (data not shown). While this is not surprising considering the restrictive Medicaid eligibility rules for most adults, and is similar to the eligibility rate among the total nonelderly adult population, it indicates that uninsured veterans' eligibility for Medicaid will rise dramatically under the ACA.<sup>22</sup> Another 40.1 percent of veterans have incomes above the ACA Medicaid threshold but low enough to potentially qualify for subsidized exchange coverage provided they do not have access to an affordable ESI offer.<sup>23</sup>

**Characteristics of Veterans with Only VA Coverage.** Table 2 also examines the characteristics of those who use VA services but have no other coverage. As might be expected based on more expansive eligibility for VA services among those with service-connected disabilities, a much higher share—38.8 percent—of those with only VA coverage have such disabilities, and 33.4 percent have a functional limitation. This group has served less recently and is older than the uninsured group: 44.4 percent last served in the Vietnam era or earlier, and nearly half (49.4 percent) are ages 55 to 64. However, like uninsured veterans, their incomes are quite low: For instance, 51.9 percent have family incomes below 138 percent of the FPL and thus would likely qualify for Medicaid coverage under the ACA, which could be used to supplement their VA coverage.<sup>24</sup>

**Table 4. Number and Percentage without Insurance Coverage, Nonelderly Veterans and Veterans' Nonelderly Family Members, by State, 2009–2010**

	Exchange Implementation	Veterans				Veterans' Nonelderly Family			
		Number Uninsured	Uninsurance Rate	Difference from Rest of U.S.	Adjusted Difference from Rest of U.S.	Number Uninsured	Uninsurance Rate	Number Uninsured	Uninsurance Rate
Massachusetts	1	9,000	4.3%*	-6.4%**	-5.7%**	3,000	1.6%*	12,000	3.0%*
Hawaii	1	3,000	5.1%*	-5.5%**	-6.1%**	2,000	2.8%*	5,000	3.9%*
Vermont	1	1,000	5.3%*	-5.3%**	-5.0%**	1,000	4.3%*	3,000	4.8%*
North Dakota	3	2,000	5.9%*	-4.7%**	-2.9%**	1,000	4.1%*	3,000	4.9%*
Connecticut	1	7,000	6.0%*	-4.7%**	-3.4%**	3,000	3.0%*	10,000	4.5%*
Maryland	1	18,000	6.5%*	-4.2%**	-1.4%**	8,000	2.8%*	25,000	4.6%*
Virginia	2	34,000	6.8%*	-3.9%**	-1.0%**	22,000	4.0%*	56,000	5.4%*
Minnesota	2	15,000	6.9%*	-3.7%**	-2.9%**	13,000	6.0%*	28,000	6.5%*
Wisconsin	2	17,000	7.1%*	-3.6%**	-3.7%**	11,000	4.5%*	29,000	5.8%*
New York	2	37,000	7.4%*	-3.3%**	-3.4%**	23,000	4.8%*	60,000	5.1%*
Iowa	2	10,000	7.9%*	-2.7%**	-2.0%**	6,000	3.8%*	16,000	5.8%*
Delaware	2	4,000	8.0%*	-2.6%**	-2.1%**	2,000	5.2%*	6,000	6.6%*
District of Columbia	1	1,000	8.2%*	-2.4%**	-3.4%*	---	---	2,000	6.2%*
Rhode Island	1	3,000	8.5%*	-2.1%**	-2.0%*	2,000	4.7%*	5,000	6.7%*
New Jersey	2	19,000	8.5%*	-2.1%**	-1.3%**	11,000	4.7%*	29,000	6.8%*
Nebraska	2	7,000	8.5%*	-2.1%**	-0.7%*	5,000	5.0%*	12,000	5.6%*
New Hampshire	3	5,000	8.5%*	-2.1%**	-0.3%*	4,000	6.3%*	10,000	7.4%*
Pennsylvania	2	47,000	9.2%*	-1.4%**	-1.7%**	30,000	5.5%*	77,000	7.3%*
Colorado	1	24,000	10.0%*	-0.6%**	0.4%*	17,000	6.3%*	41,000	8.1%*
California	1	108,000	10.0%*	-0.6%**	-1.1%**	71,000	6.5%*	180,000	8.2%*
Maine	2	7,000	10.1%*	-0.5%**	-0.7%*	4,000	5.1%*	11,000	7.7%*
Washington	1	37,000	10.1%*	-0.5%**	0.7%*	23,000	6.4%*	60,000	8.2%*
Illinois	2	43,000	10.1%*	-0.5%**	-1.0%**	25,000	5.6%*	68,000	7.8%*
Ohio	3	52,000	10.3%*	-0.3%**	-1.5%**	35,000	6.8%*	87,000	8.5%*
Missouri	2	30,000	10.3%*	-0.1%**	-0.5%*	22,000	7.2%*	52,000	8.8%*
Arizona	2	32,000	10.6%*	0.0%**	-0.3%*	24,000	7.9%*	55,000	9.2%*
Kentucky	2	22,000	11.0%*	0.4%**	0.2%*	19,000	9.1%*	41,000	10.0%*
Alabama	2	27,000	11.0%*	0.5%**	1.0%*	20,000	7.7%*	47,000	9.4%*
Michigan	2	44,000	11.4%*	0.9%**	-0.8%**	29,000	7.4%*	73,000	9.4%*
South Dakota	3	4,000	11.5%*	0.9%**	1.7%*	4,000	9.6%*	8,000	10.5%*
Utah	1	10,000	11.7%*	1.1%**	0.8%*	10,000	8.5%*	20,000	9.9%*
Kansas	3	15,000	11.7%*	1.2%**	1.3%*	10,000	7.7%*	25,000	9.7%*
North Carolina	2	54,000	11.8%*	1.3%**	1.0%**	43,000	8.7%*	97,000	10.2%*
Tennessee	2	35,000	11.9%*	1.3%**	1.0%**	20,000	6.9%*	56,000	9.3%*
Indiana	1	33,000	12.0%*	1.4%**	0.2%*	24,000	8.1%*	58,000	10.0%*
Nevada	1	16,000	12.1%*	1.6%**	0.9%*	14,000	11.1%*	30,000	11.6%*
Georgia	3	56,000	12.2%*	1.7%**	1.5%**	42,000	8.3%*	98,000	10.2%*
West Virginia	1	11,000	12.4%*	1.9%**	1.2%*	9,000	9.4%*	20,000	10.9%*
Alaska	3	7,000	12.5%*	1.9%**	3.4%**	6,000	10.1%*	13,000	11.2%*
South Carolina	3	30,000	12.5%*	1.9%**	1.5%**	23,000	9.1%*	53,000	10.7%*
New Mexico	2	13,000	12.7%*	2.2%**	1.3%*	7,000	7.3%*	20,000	10.1%*
Florida	3	106,000	13.0%*	2.6%**	1.7%**	81,000	10.2%*	186,000	11.6%*
Texas	3	130,000	13.1%*	2.7%**	3.1%**	118,000	10.8%*	248,000	11.9%*
Mississippi	2	16,000	13.3%*	2.8%**	2.2%**	13,000	10.1%*	29,000	11.7%*
Wyoming	3	5,000	13.4%*	2.8%**	4.0%**	3,000	7.5%*	7,000	10.4%*
Arkansas	3	20,000	13.6%*	3.1%**	2.3%**	17,000	11.0%*	37,000	12.3%*
Oklahoma	3	26,000	13.8%*	3.3%**	3.2%**	23,000	11.9%*	49,000	12.8%*
Louisiana	3	27,000	14.1%*	3.5%**	3.2%**	19,000	9.6%*	46,000	11.8%*
Oregon	1	27,000	14.3%*	3.8%**	2.5%**	18,000	9.6%*	45,000	12.0%*
Idaho	2	10,000	14.8%*	4.2%**	3.4%**	8,000	10.4%*	19,000	12.5%*
Montana	2	9,000	17.3%*	6.7%**	5.3%**	7,000	14.0%*	16,000	15.7%*

Notes: Based on the 2009 and 2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). Estimates reflect additional Urban Institute adjustments for the underreporting of Medicaid/CHIP and the overreporting of private nongroup coverage (see Lynch et al. 2011). Nonelderly veterans are ages 19 to 64. Family members of veterans are defined in the appendix. (\*) indicates the state rate is significantly different from the national average at the 0.05 level. Exchange implementation groupings are derived from Blavin, Suetters, and Roth (2012) and are as follows: (1) Most Progress—the 15 states that have made the greatest progress either through enacting establishment legislation or via executive order; (2) Moderate Progress—the 21 states that have expressed intent to develop an exchange, or that have received a federal establishment grant; and (3) Least Progress—the 15 states that have made the least progress, including some states that have created a study entity/planning committee and others in which legislative action was not taken or did not pass. Estimates are rounded to the nearest thousand. Adjusted differences control for socioeconomic and demographic characteristics of veterans. Uninsurance indicates the person lacks comprehensive coverage and does not use VA health services.

**Table 5. Number and Percentage without Insurance Coverage, Nonelderly Veterans and Veterans' Nonelderly Family Members, According to State Progress with Respect to Exchange Implementation Under the ACA, 2010**

	Veterans		Family Members of Veterans		Veterans and Their Families	
	Number Uninsured	Uninsurance Rate	Number Uninsured	Uninsurance Rate	Number Uninsured	Uninsurance Rate
United States	1,314,000	10.5%	948,000	7.4%	2,252,000	9.0%
<b>Exchange Implementation:</b>						
Most Progress	303,000	9.6%*	197,000	6.2%*	500,000	7.9%*
Moderate Progress	524,000	9.8%*	365,000	6.6%*	889,000	8.2%*
Least Progress	487,000	12.3%*	386,000	9.4%*	873,000	10.8%*

Notes: Based on the 2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). Estimates reflect additional Urban Institute adjustments for the underreporting of Medicaid/CHIP and the overreporting of private nongroup coverage (see Lynch et al. 2011). Nonelderly veterans are ages 19 to 64. Family members of veterans are defined in the appendix. (\*) indicates the exchange implementation group's rate is significantly different from the national average at the 0.05 level. Exchange implementation groupings are derived from Slavin, Bueltgens, and Roth (2012) and are as follows: (1) Most Progress—the 15 states that have made the greatest progress either through enacting establishment legislation or via executive order; (2) Moderate Progress—the 21 states that have expressed intent to develop an exchange, or that have received a federal establishment grant; and (3) Least Progress—the 15 states that have made the least progress, including some states that have created a study entity/planning committee and others in which legislative action was not taken or did not pass. Estimates are rounded to the nearest thousand. Uninsurance indicates the person lacks comprehensive coverage and does not use VA health services.

**Table 6. Unmet and Delayed Medical Needs and Health Problems, Nonelderly Veterans and Veterans' Nonelderly Family Members, by Insurance Status, 2009–2010**

	Veterans		Family Members of Veterans	
	Uninsured	Insured	Uninsured	Insured
Any Unmet (nondental) Health Needs	41.2%**	12.7%	54.8%**	12.3%
Unmet Dental Needs	39.5%**	11.4%	38.3%**	10.5%
Delayed Care Due to Cost	33.7%**	8.4%	44.1%**	7.6%
Has a Chronic Condition*	33.0%**	49.1%	--	--
Is in Fair or Poor Health	15.3%	16.3%	15.5%*	7.2%
Limited Because of Physical, Mental or Emotional Problems	15.9%**	21.2%	11.6%	11.9%
Negative Feelings Interfered with Life/Activities, a Lot/Some of Last 30 Days	40.1%	34.0%	--	--

Notes: Based on the 2009 and 2010 National Health Interview Survey. Indicators for unmet needs and delayed care refer to problems in access over the past 12 months. (\*\*) indicates that the insured percentage is significantly different from the uninsured percentage at the 0.05(0.01) level. (+) indicates person has one or more of the following health problems: asthma, diabetes, emphysema, heart disease or condition, hypertension, stroke, or weak/failing kidneys. Indicators for emphysema, hypertension, stroke, weak/failing kidneys, and negative feelings interfering with life/activities are not available for children, so estimates for chronic conditions and negative feelings interfering with life/activities are not shown for family members of veterans. Uninsurance indicates the person lacks comprehensive coverage and does not use VA health services.

Uninsured rates among veterans vary across states: For example, four states have uninsurance rates below six percent, and four states have uninsurance rates higher than 14 percent. This variation remained even after controlling for differences in veterans' characteristics across states. Uninsurance appears higher among veterans who live in states that have thus far done the least to implement health insurance exchanges under the ACA. A number of uninsured veterans have functional limitations, and many are experiencing difficulties getting access to needed health care. When family members of veterans are considered, the uninsured total rises to 2.3 million. In addition, another 0.9 million veterans use VA health care but have no other coverage.

We find that uninsured veterans have served more recently, are younger, are less likely to be married, have lower

levels of educational attainment, and have less connection to the labor force than insured veterans, which likely constrains their access to employer-based health insurance coverage.

Although under current rules, nearly all uninsured veterans and the majority of their uninsured family members do not qualify for comprehensive Medicaid coverage, increased Medicaid enrollment among the uninsured who are currently eligible would lower their uninsurance rate. Greater use of the VA system could also address some of the unmet needs among veterans.<sup>31</sup>

It appears that the ACA could offer new routes to health insurance coverage for veterans and their family members. Fully 48.8 percent of uninsured veterans and 35.5 percent of their uninsured family members have incomes below 138 percent of the FPL, indicating that they would likely qualify for coverage once the Medicaid expansion is implemented

in January 2014. In addition, more than half of veterans reporting only VA care could qualify for Medicaid to supplement their VA care under the expansion that is slated under the ACA. Another 40.1 percent and 49.0 percent of uninsured veterans and family members, respectively, have incomes that could allow them to qualify for new subsidies for coverage through health insurance exchanges provided they do not have access to affordable ESI.

Expanded coverage among these groups will not solve every access problem. For example, the problems that uninsured veterans report with unmet dental needs are not directly addressed by the ACA. In addition, while insurance coverage is associated with increased access to care,<sup>32</sup> additional interventions may be needed in order to address access gaps. For example, some of the veterans who lack coverage and are experiencing access problems may have specialized

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# Medicaid Expansion & Mental Health Care

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# Medicaid Expansion and Mental Health Care

## Introduction

The tragic shooting in Newtown, Connecticut and others have stimulated public discussion about the failed mental health system in America. After cuts of nearly \$4.35 billion to public mental health programs from 2009-2012<sup>1</sup>, mental health services simply are not available to many Americans who need help. With fewer than half of Americans who live with mental illness getting any treatment<sup>2</sup>, concern is growing about lack of access to mental health services. People are asking, "Where can I get mental health services if I don't have health insurance and can't afford care?"

**As of the date of publication of this report, only 20 states and the District of Columbia have committed to expanding their Medicaid programs. The facts are clear – six out of ten Americans living with serious mental illness have no access to mental health care at all. Glaring gaps in treatment of this kind would not be tolerated for heart disease, cancer or diabetes and they should not be tolerated for mental illness either. States that decline to expand Medicaid will miss as good an opportunity as they may ever have to address this shameful void in access to mental health treatment. See Appendix V to check the status of Medicaid expansion in your state.**

Hoping to improve access, some lawmakers are pledging to invest in mental health care. One significant step that states can take is to extend Medicaid to 138 percent of the Federal Poverty Level (FPL), an option available to states as a result of the health reform law, the Patient Protection and Affordable Care Act (ACA).

Medicaid is the most important source of financing for mental health services in America today, offering mental health services that would otherwise be out of reach for low-income people affected by mental illness. Medicaid's role in

mental health care has increased, and today the federal/state health financing program pays for nearly half of all publicly-funded mental health services.

**Expanding Medicaid will fill critical gaps in access to health and mental health care, reduce uncompensated crisis care and pave the way to recovery and economic self-sufficiency for millions of Americans.**

A broad array of vital mental health services and supports are covered by Medicaid. For many, like Sharon's son, Medicaid mental health services are life-changing:

"Three years ago, my son was in a very dark place. He was flunking out of school and living a life of seclusion. He holed up in his room while the rest of the family walked on eggshells. Today, he is a completely different person. It took three years of counseling and finding the right medication for his bipolar disorder, but we did it. If we didn't have Medicaid, I don't know where he would be right now. He not only is doing fantastic in school and life, he has begun to really talk about his illness. He wants other kids to know that there is nothing to be ashamed of." – Sharon

## A Snapshot of Medicaid Mental Health Benefits

Medicaid is a life-saving program that provides health and mental health care to low-income children, pregnant women, families, people 65 or older, and certain people with disabilities. Medicaid is particularly important for children and adults with mental illness, offering vital services and supports that are typically not covered by private insurance.

Medicaid is the most important source of funding for mental health services. In 2008, 46 percent of state controlled funds for mental health services came from Medicaid.

<sup>1</sup> Joel E. Miller, et al., November 2012. "The Waterfall Effect: Transforming the Cascading Impact of Medicaid Expansion on States," National Association of State Mental Health Program Directors.  
<sup>2</sup> Substance Abuse and Mental Health Services Administration. (2012). Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings

**7.6 million**  
Emergency department visits were  
for mental illness in 2007.

**1 in 8**  
were uninsured.

- Over 7 million emergency department visits a year are made by people living with mental illness and more than one in eight is uninsured.<sup>7</sup>
- Mood disorders are the third most common reason children and adults to age 44 are hospitalized.<sup>8</sup>
- There are more than 38,000 suicides every year in America—more than double the number of homicides.<sup>9</sup>
- Over one in five people in jail and prison live with a mental illness. Many of these individuals would not have come into contact with criminal justice systems had they received timely and effective treatment.<sup>10,11</sup>
- 70 percent of young people in juvenile facilities have a diagnosable mental health condition.<sup>12</sup>

Expanding Medicaid will help people get mental health services before their symptoms get worse and they experience debilitating, or even tragic, outcomes.

### Expanding Medicaid, a springboard to recovery

Medicaid coverage helps people stay healthy. A recent study of Medicaid expansion in Oregon found that people enrolled in Medicaid see their doctors more often, get more preventive care and report better health and financial stability.<sup>13</sup> A *New England Journal of Medicine* study found that expanding Medicaid reduces the death rate for adults, particularly for minorities and people living in low-income areas.<sup>14</sup>

**Expanding Medicaid helps people get back to work and become self-sufficient.** Many people living with mental illness want to work, but are afraid of losing their Medicaid coverage. By expanding Medicaid, people can go back to work yet stay in mental health care by transferring to a qualified health plan offered through their state's health insurance marketplace.

*"For many of the people in the expansion population, particularly young people with mental illness or substance abuse problems, the new health coverage is expected to rapidly change their earning ability. You'll see many of them rocket out of poverty. If their treatments are interrupted because they lose Medicaid coverage, it could send them back into a downward spiral."*  
- Matt Salo, Director, National Association of Medicaid Directors<sup>15</sup>

In addition, expanding Medicaid will help many people who are reluctant to sign up for disability benefits or who experience challenges with an often daunting disability process. In states that expand Medicaid, it will be easier for people to get and keep coverage for mental health services.

<sup>7</sup> Pamela L. Owens, Ph.D., et al, July 2010. "Mental Health and Substance Abuse-Related Emergency Department Visits among Adults," Agency for Healthcare Research and Quality.

<sup>8</sup> LM Wier (Thompson Reuters), et al, 2011. "HCUP Facts and Figures: Statistics on Hospital-based Care in the United States, 2009," Agency for Healthcare Research and Quality.

<sup>9</sup> J.L. McIntosh, January 2012. "U.S.A. suicide: 2009 official final data," American Association of Suicidology.

<sup>10</sup> Kathleen Skowrya and Joseph J. Cocozza, Ph.D., June 2006. "A Blueprint for Change: Improving the System Response to Youth with Mental Health Needs Involved with the Juvenile Justice System," National Center for Mental Health and Juvenile Justice.

<sup>11</sup> Doris J. James and Lauren E. Glaze, September 2006. "Mental Health Problems of Prison and Jail Inmates," Bureau of Justice Statistics Special Report.

<sup>12</sup> Teplin, L., Abram, K., McClelland, G., Dulcan, M., and Mericle, A. (2002). "Psychiatric disorders in youth in juvenile detention." *Archives of General Psychiatry*, 59, 1133-1143.

<sup>13</sup> Amy Finkelstein & Sarah Taubman & Bill Wright & Mira Bernstein & Jonathan Gruber & Joseph P. Newhouse & Heidi Allen & Katherine Baicker, 2012. "The Oregon Health Insurance Experiment: Evidence from the First Year," *The Quarterly Journal of Economics*, Oxford University Press, vol. 127(3), pages 1057-1106. Web. <http://www.nber.org/papers/w17190>.

<sup>14</sup> Benjamin D. Sommers, M.D., Katherine Baicker, Ph.D. and Arnold M. Epstein, M.D., September 2012. "Mortality and Access to Care among Adults after State Medicaid Expansions," *New England Journal of Medicine*, vol. 367, pages 1025-1034. <http://www.nejm.org/doi/full/10.1056/NEJMsa1202099>.

<sup>15</sup> Vestal, C. (Mar. 22, 2013) Ohio, Arkansas May Provide New Model For Insuring Low-Income Residents. Kaiser Health News. Accessed: 4/3/2013: <http://www.kaiserhealthnews.org/Stories/2013/March/22/medicaid-expansion-private-insurance-states.aspx>.

## **Take Advantage**

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### **of New Opportunities to Expand Medicaid Under the Affordable Care Act**

*A guide to improving health coverage and  
mental health services for low-income  
people, following the Supreme Court  
ruling on the Affordable Care Act.*

July 2012

### Advocacy Points for These Policies

- ❖ Home and community-based services are extremely cost-effective services for a state to cover, and the ACA now presents an opportunity for people with mental illness to fully benefit from these services.
- ❖ States can target a 1915(i) option as narrowly as they wish, limiting both eligibility and services covered and thus reducing their exposure to costs.
- ❖ Some states have used this option exclusively to cover services previously funded only through state dollars. This strategy is a win-win—for the state that saves resources, and for the individual who receives needed services.

### Arguments in Support

Home and community-based services have been covered under Medicaid through waivers of federal rules for many years. However, few states have such waivers for people with mental illness. This is due to the waiver rule that the community services may not be more expensive than Medicaid-covered institutional services that would have been used absent the waiver.

Because services in an Institution for Mental Diseases (IMD)<sup>o</sup> are not covered under Medicaid for individuals aged 22-64, home and community-based waivers for adults with mental illness have been very difficult to obtain. For children, placement in a psychiatric residential treatment facility is a covered Medicaid service, but this type of facility is not considered an “institution” for purposes of the waiver. As a result, there have been very few waivers for children with mental health disorders.

Section 1915(i) changes the rules, because there is no requirement that home and community-based services must be cost neutral to Medicaid by offsetting institutional costs.

The law also gives states great flexibility to target Section 1915(i), both by how the state defines the population to be eligible and by the service array it covers. Several states, such as Iowa, Wisconsin and Oregon, have chosen to target individuals with serious mental illness, providing access to various psychosocial rehabilitation and behavioral services.

The types of services that can be covered under Section 1915(i) include a number of inexpensive, but effective, options, such as respite care and peer support. Other services can fill in the service array—such as paying the full cost of supported employment, including a job coach, or helping establish someone in independent housing. Currently, these costs are frequently borne by mental health systems.

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<sup>o</sup> IMDs are primarily psychiatric hospitals and nursing homes whose resident population has a significant percentage of people with mental illness. Other facilities that meet a federal regulatory definition are also IMDs.

## Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case

By Michael Nardone, Richard Cho and Kathy Moses

JUNE 2012

For many individuals with complex chronic health conditions, homelessness and housing instability can be the most significant impediments to health care access, often resulting in excessive utilization of expensive inpatient and crisis services. For these individuals, supportive housing offers an evidence-based solution to improving health outcomes while reducing costs.

By providing stable affordable housing coupled with “high touch” supports that connect people with chronic health challenges to a network of comprehensive primary and behavioral health services, supportive housing can help improve health, increase survival rates, foster mental health recovery, and reduce alcohol and drug use among formerly homeless individuals. To help states prepare for Medicaid expansion and anticipate the needs of this high-need population subset, this brief:

1. Outlines the potential benefits of care management linked to affordable housing;
2. Details the business case for using Medicaid to finance supportive housing-based services from the viewpoint of Medicaid as well as the supportive housing industry sector;
3. Highlights potential Medicaid authorities that states can use to fund supportive housing-based services; and
4. Raises considerations for policymakers to address in designing strategies that use Medicaid resources to provide supportive housing-based services for people who are homeless.

### Opportunities for Supportive Housing in Health Reform

Although supportive housing has long been a beneficial approach for individuals with chronic illnesses (and resulting high costs) who are homeless, the Affordable Care Act (ACA) increases opportunities for states and communities to take advantage of supportive housing's benefits:

1. Nearly all homeless chronically ill adults will be Medicaid-eligible beginning in 2014.
2. The ACA's creation of a new state plan option for health home services gives explicit priority to coordinating care for beneficiaries with mental illnesses, substance use disorders, and other chronic conditions that are often found among tenants of supportive housing.

### IN BRIEF

Medicaid expansion under the Affordable Care Act (ACA) will provide new insurance coverage to more individuals who are homeless. States could consider leveraging various Medicaid service options, such as health homes, to provide these new beneficiaries with care management services linked to supportive housing.

Medicaid-financed care management in supportive housing for high-risk homeless Medicaid beneficiaries could yield a significant ROI from reduced hospitalizations and emergency department use. Growth in Medicaid managed care for these individuals, particularly after 2014, will expand opportunities to capitalize on care management linked to supportive housing with the prospect for sharing associated savings across providers, health plans, and states.

This brief outlines the rationale for states to consider designing Medicaid-financed, supportive housing-based care management services to improve care for at-risk beneficiaries while lowering costs associated with avoidable hospitalizations and other crisis services.

## Defining Care Management Linked to Affordable Housing

Care and case management terms have specific connotations based on the setting in which they are used (e.g., Medicaid, supportive housing, behavioral health). Throughout this paper, we refer to *care management linked to affordable housing*. In so doing, we seek to distinguish the services offered within supportive housing from other forms of care and case management. Housing-based care management services are: (a) provided in and around the beneficiary's home to make the services as accessible as possible; and (b) focused on ensuring housing stability, recognizing housing's role as an essential platform for recovery and improved health.

These changes may compel states to consider developing a Medicaid-focused supportive housing strategy for individuals experiencing, or at-risk of, homelessness. States can consider using supportive housing to bend the Medicaid cost curve, namely, by improving outcomes and reducing costs among homeless or precariously housed high-cost Medicaid beneficiaries. In turn, with Medicaid becoming a more viable means of paying for care management linked to affordable housing, states can consider using Medicaid to leverage investments from affordable housing sectors to cover the capital and operating costs for supportive housing.

## Background

Prior to the ACA, many chronically homeless adults, including those residing in supportive housing, were not eligible for Medicaid. Beginning in 2014, nearly all homeless persons will, by virtue of their incomes, be eligible for Medicaid. Given the anticipated health needs of the homeless subset of the expansion population, states have a compelling opportunity to invest in care management and other well-targeted services that have the potential to divert the need for more expensive utilization down the road.

Across Medicaid, roughly five percent of beneficiaries account for 50 percent of program costs. The high prevalence of mental illness, substance abuse, and co-occurring physical disorders in the

chronically homeless population suggests that many of these individuals, once folded into state Medicaid programs, could become part of this cohort driving Medicaid costs. Managing care for these individuals, therefore, will be critical to efforts to control overall program costs.

At the same time, the ACA provides additional resources and program authorities that can support innovations in serving this population. In most states, the ACA will initially provide 100 percent federal funding for individuals with incomes under 138 percent of the federal poverty level and not currently eligible for Medicaid, including people who are homeless. Although this level of support will decline over five years to a 90 percent federal match, it provides states with a valuable window for improved chronic care management prior to paying a state share of the costs. In addition, the ACA also creates a new state plan option that provides 90 percent federal match for eight quarters for the establishment of "health homes." This new service option is available for people with serious mental illness or multiple chronic conditions, including mental health and substance abuse disorders, which are highly prevalent among the chronically homeless.

## Demographics and Health Care Needs of the Homeless

According to the U.S. Department of Housing and Urban Development's 2010 Annual Homeless Assessment Report (AHAR) to Congress, approximately 1.2 million people across the nation were homeless and used emergency shelters or transitional housing for at least one night during 2010. Roughly two-thirds of these were single adults and approximately 10 percent were chronically or long-term homeless.

Since chronic physical and mental health conditions may contribute to a person becoming homeless, it is no surprise that there is a higher prevalence of these

conditions among people in emergency shelters, living on the street or cycling in and out of institutional settings. Homeless adults, particularly those who are chronically or long-term homeless, are far more likely to suffer from chronic medical conditions, such as HIV/AIDS, hypertension and diabetes and to suffer complications from their illness due to lack of housing stability and regular, uninterrupted treatment.<sup>2</sup> In 2010, an estimated 46 percent of adults in housing shelters had a chronic substance abuse problem and/or a severe mental illness. For those in supportive housing, 82 percent have a mental or physical health disability, more than half had a substance abuse and/or serious mental health condition, and 6.4 percent had HIV/AIDS.<sup>3</sup> Mortality rates among homeless adults are three or more times greater than that of the general population.

Due to the high incidence of chronic illness and lack of regular care, health care costs, particularly crisis-related, for individuals who are homeless are excessive. The Boston Health Care for the Homeless program, which followed a cohort of 119 homeless adults, found that these individuals accounted for 18,384 emergency department (ED) visits and 871 medical hospitalizations over a five-year period with average annual health care costs of \$28,436.<sup>5</sup> In the California Frequent Users of Health Services Initiative, which sought to link high ED users with care management supports, approximately 45 percent of the individuals who met the criteria of frequent users were also homeless individuals.<sup>6</sup> And a New York study identifying risks for hospital admissions found that individuals who were high users of hospital services (>\$39,000 on average) and at risk for future admissions had a high prevalence of homelessness – 60 percent reported being homeless or in precarious housing situations with family or friend.<sup>7</sup> These individuals were also much more likely to name the ED as their usual source of care and to have a hospital stay related to substance abuse or mental illness.

Estimates on the percentage of people living in homelessness who are eligible for Medicaid vary widely depending on state eligibility policies; however, in most states the Medicaid program does not currently cover homeless single adults. For example, HUD's AHAR<sup>8</sup> reports on low initial eligibility rates (10-15 percent) among homeless individuals for Supplemental Security Income (SSI), which would also make them categorically eligible for Medicaid. Most states have not expanded coverage to single adults not eligible for SSI. Only 22 percent of clients receiving services through the Health Resources and Services Administration's Healthcare for the Homeless program are enrolled in Medicaid.<sup>9</sup> Application requirements for Medicaid, such as proof of citizenship, also pose a barrier to enrollment in the Medicaid program for chronically homeless individuals. In addition, service providers are often reluctant to make a shift to adopting Medicaid-coverable services and billing practices.

### **Supportive Housing: Review of Evidence and Outcomes**

Supportive housing linked with care management connects stable, affordable housing with a team of clinical and support staff to help individuals gain access to primary and behavioral health care services. Research from programs across the country<sup>10</sup> has demonstrated that linking care management to supportive housing can dramatically improve health outcomes:

- A Denver study<sup>11</sup> found 50 percent of tenants in supportive housing experienced improved health status, 43 percent had better mental health outcomes, and 15 percent reduced substance use;
- A Seattle<sup>12</sup> study found 30 percent reduction in alcohol use among chronic alcohol users in supportive housing;
- Both a San Francisco<sup>13</sup> and a Chicago<sup>14</sup> supportive housing project had significantly higher survival rates for

Mortality rates among homeless adults are three or more times greater than that of the general population.

3. *Technical assistance and/or new organizational configurations are needed to help bridge the gap between current supportive housing capacity and Medicaid requirements (e.g., billing, quality).*

The capacity of supportive housing organizations will need to be strengthened to support their efforts to serve as providers and appropriately bill for services under the Medicaid program. States and/or MCOs should be ready to provide technical assistance to supportive housing providers and facilitate their enrollment and participation in the Medicaid program. This may include providing assistance to existing providers to structure, track, and describe the services they deliver in terms that will allow for Medicaid billing and payment.

Alternatively, current providers of Medicaid services can play a role in providing services in supportive housing. For example, health home teams or MCO community-based care managers could potentially support beneficiaries residing in supportive housing environments. Administrative services organizations (ASOs) could serve as intermediaries between supportive housing providers and Medicaid, specifically to conduct centralized tracking and Medicaid billing on behalf of providers.

4. *Systems and methods are needed for tracking and managing costs for people who are chronically homeless.*

States and housing providers will need data and information systems that can track health outcomes, service utilization, and costs once clients are receiving services in supportive housing settings. Such "real-time" systems can help ensure that savings are being realized to offset the cost of services and help build the case for future investment in these services.

Depending on the state strategy employed, MCOs or ASOs could be used to track and manage service delivery, outcomes, and costs.

### Conclusion

There is compelling evidence that a combined intervention of stable, affordable housing along with supportive services can pay off in reduced utilization of crisis and inpatient services, resulting in better health care outcomes for individuals with complex needs who are homeless, and improved management of costs for Medicaid. There are also potential benefits to other public systems, such as corrections to the extent that the model can reduce incarceration rates among targeted populations.

Developing strategies to use Medicaid-funded services to address the health needs of supportive housing residents, and overcoming the aforementioned policy challenges, could represent a good investment opportunity for states – particularly as national health reform expands Medicaid eligibility to all individuals with incomes below 138 percent of the federal poverty level. In short, it is an investment that states should consider as part of their preparation for implementing the ACA in 2014.

### APPENDIX T

# MEDICAID EXPANSION

## IMPROVING HEALTH & STABILITY, REDUCING COSTS & HOMELESSNESS



The Supreme Court decision giving states the option to extend Medicaid eligibility to most adults earning at or below 138% of the federal poverty level (FPL) has led to a discussion over the costs and benefits of the program itself and the merits of expansion. Lost in this debate has been the poor health status of those newly eligible—which include many of those experiencing homelessness—and the opportunities for a more healthy and productive life offered through Medicaid. Foregoing the Medicaid expansion extends beyond politics, and has a direct impact on the life, health, and economic stability of both individuals and states. To fully consider the impact Medicaid expansion would have on states, it is necessary to consider the connection between poor health and poverty, the demonstrated benefits of Medicaid, and the cost savings that states can realize from full implementation of the expansion option.

### Medicaid expansion is critical to improve the health of people without homes

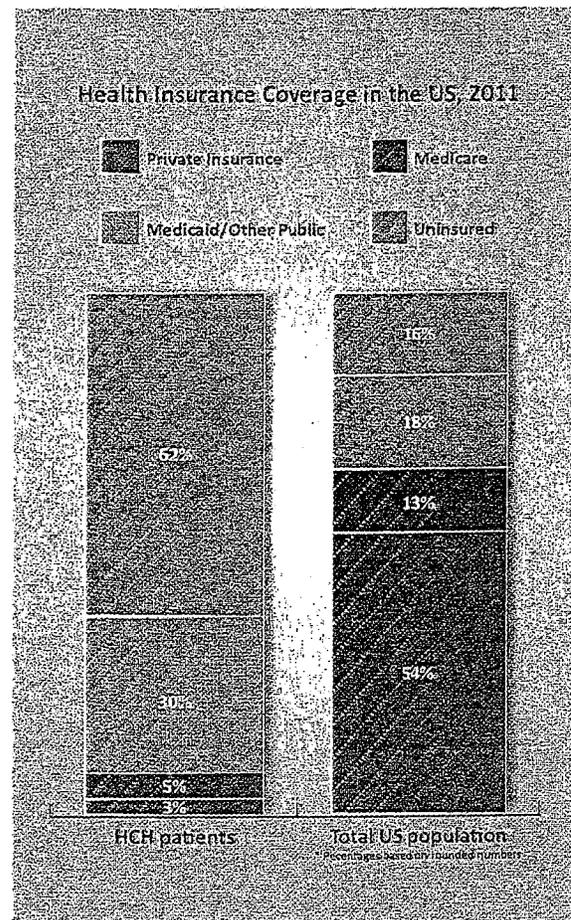
Poor nutrition, inadequate hygiene, exposure to violence and weather-related illness and injury, increased risk of contracting communicable diseases, and the constant stress of housing instability all contribute to poor health; poor access to health care services exacerbates these circumstances.<sup>1</sup> Without housing and health care, simple cuts become infected, routine colds develop into pneumonia, and manageable chronic diseases such as asthma, hypertension, diabetes, and HIV become disabling, life-threatening and costly conditions. Medicaid provides the consistent health coverage needed to prevent and treat the health issues of individuals experiencing homelessness and remains the primary health insurance option open to those living in poverty.

#### People without homes have poor health:

- Die 30 years earlier than their housed counterparts.<sup>2</sup>
- Suffer injury 3-6 times the rate of general population.<sup>3</sup>
- In January 2010, 26% of shelter population was found to have severe mental illness and 35% to have a substance use disorder, often co-occurring.<sup>4</sup>

#### People without homes are largely uninsured:

- 62% of patients served by Health Care for the Homeless projects were uninsured in 2011, much higher than the general population (see figure above).<sup>5</sup>
- Adults without dependent children or a disability are ineligible for Medicaid in most states.



Source: Kaiser Family Foundation, State Health Facts; HRSA, 2011 National Homeless Data.

APPENDIX U

### Medicaid expansion is the only coverage option for people without homes:

- Nearly all those experiencing homelessness are under 100% FPL and thus, unable to afford insurance and ineligible for subsidies in the state-based health exchanges.
- Demonstrating disability is often needed to qualify for Medicaid, but the determination process is especially difficult for people without homes. They are only successful on their first application 10-15% of the time.<sup>6</sup>

### Medicaid provides effective health coverage:

- States that have previously expanded Medicaid to adults have had significant reductions in mortality.<sup>7</sup>
- The Oregon Health Study found Medicaid coverage resulted in significant increases in having a regular source of care, using preventive services, and reporting improved health status.<sup>8</sup>
- Medicaid beneficiaries report health care access comparable to those with private health insurance.<sup>9</sup>

### Medicaid expansion is critical to maintain or regain stability

Homelessness is often the result of a downward spiral: illness results in loss of employment—and in turn, income, housing, and health coverage (if offered in the first place). Reliable coverage through Medicaid can break this cycle before it starts. Individuals can receive regular treatment for chronic conditions before they become disabling, prevent chronic illnesses from developing, and access needed behavioral health services. Additionally, Medicaid provides financial security both to those suffering with a chronic illness or those struck with a sudden, catastrophic injury or illness. For those on the street for many years, regaining stability is more challenging, often requiring intensive supportive services only available either through small targeted programs or through Medicaid. Expansion can help make these models of support more widely available, thus increasing housing stability and reducing homelessness.

### Medicaid improves financial security and helps prevent homelessness:

- 62% of personal bankruptcies are caused by medical debt.<sup>10</sup>
- Medicaid reduces by 40% the need to borrow money or skip payments due to medical expenses.<sup>11</sup>
- Medicaid reduces by 25% the chance someone will have medical bills referred to a collection agency.<sup>12</sup>

### Medicaid expansion will stabilize health and reduce homelessness:

- Medicaid improves care coordination by providing access to specialists, needed surgery, and other ambulatory care not typically offered by providers that may be accessible to those without coverage.
- Disabled people who want to return to work currently risk losing insurance due to employment income, a significant impediment to re-entering the workforce.<sup>13</sup> Medicaid expansion solves this problem.
- Access to behavioral health treatment increases worker productivity and decreases absenteeism.<sup>14</sup>
- Medicaid expansion can improve access to permanent supportive housing programs, shown to improve health status and mental health outcomes, reduce substance use, and increase survival rates for people with HIV.<sup>15</sup> After one year, 83% remain in housing; after two, 77% remain housed.<sup>16</sup>

### Medicaid expansion is critical to improve state budgets & lower health care costs

The federal government is providing the vast majority of funding needed for Medicaid expansion. A recent Kaiser Family Foundation analysis found the difference in state Medicaid spending between all states expanding and none to be \$8 billion over ten years, a 0.3% increase (see figure next page). This 0.3% increase in state spending would result in nearly \$1 trillion new federal spending and approximately 16 million residents obtaining coverage.<sup>17</sup> One reason for this small increase is the 'woodwork effect', meaning the publicity of the ACA insurance expansions will lead currently eligible individuals to apply for Medicaid coverage (likely to occur regardless a state's decision on expansion). Another reason is that states

# Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?

## Timely Analysis of Immediate Health Policy Issues

August 2012

Authors: Jeffrey M. Kenney, Stephen Zuckerman, Lisa Dubay, Michael Burgess, Patricia A. Rosen, Alan M. Gold, and Amanda M. Gattuso

### Summary

At present, few states cover non-disabled, non-pregnant parents with incomes up to 138 percent of the federal poverty level (FPL) and even fewer cover such adults without dependent children. With the implementation of the coverage provisions of the Affordable Care Act (ACA), Medicaid eligibility could increase dramatically for these groups. This analysis suggests that the approximately 15.1 million uninsured adults who could gain coverage under the ACA Medicaid expansion are a diverse group in terms of their age and race/ethnicity. Though over half of this group is under age 35, 35 percent are between the ages of 35 and 54 and over 10 percent are near elderly adults between the ages of 55 and 64. Nationwide, just over half are white, but their racial and ethnic composition varies substantially

across states. And while over four in five of these uninsured are adults who are not living with dependent children, 2.7 million are parents living with dependent children. Just over half (53 percent) of the uninsured who could gain coverage under the Medicaid expansion are male, but 4.6 million are women of reproductive age. States are now weighing whether to expand Medicaid under the ACA—some states have expressed concern that expanding Medicaid to more adults may pose fiscal challenges. However, purely monetary calculations ignore the potential human, financial, and productivity benefits associated with improved access to affordable health care for the millions of low-income adults without health insurance coverage and their families.

### Introduction

The Supreme Court's ruling on the Affordable Care Act (ACA) put the decision to expand Medicaid coverage to nonelderly adults with incomes below 138 percent of the federal poverty level (FPL) in the hands of the states.<sup>1</sup> Discussions about whether or not states plan to expand Medicaid under the ACA have been dominated by budgetary concerns, particularly regarding potential state outlays and offsets associated with the Medicaid expansion. While there are legitimate concerns about the budgetary aspects of this decision, there has been relatively little focus on the characteristics of the people who would be affected.

Currently, few states cover non-disabled, non-pregnant parents up to 138 percent of FPL in Medicaid, and even fewer states cover such adults without dependent children. At present, only 18 states provide comprehensive Medicaid coverage to parents at or above 100 percent of FPL (\$18,530 for a family of three in 2011), and the median state

covers working and non-working parents up to only 63 and 37 percent of FPL, respectively. The majority of states do not cover non-disabled, non-pregnant adults without dependent children at any income level, and many low-income women only qualify for Medicaid coverage when they are pregnant.<sup>2</sup> As has been noted, "it's a very common misconception that Medicaid covers all poor people, but that's far from the truth."<sup>3</sup> In contrast, children in this income range are already eligible for Medicaid or the Children's Health Insurance Program (CHIP) in every state. As a consequence, children with incomes below 138 percent of FPL are much more likely than parents and nonelderly adults without dependent children to have Medicaid/CHIP coverage and much less likely to be uninsured.<sup>4</sup> In 2010, over 40 percent of the adults in this income group were uninsured, compared to 16 percent of children.<sup>5</sup>

States are considering whether or not to implement the ACA option of expanding Medicaid to adults with incomes up

to 138 percent of FPL (approximately \$15,000 for an individual).<sup>6</sup> If a state does not implement the Medicaid expansion, some adults could instead receive federal tax credits and other subsidies when purchasing coverage through the newly created exchanges, but these credits and subsidies would not be available for citizens with incomes below 100 percent of FPL.

State decisions regarding whether to expand Medicaid under the ACA will affect an estimated 15.1 million uninsured adults with incomes below 138 percent of FPL who would be newly eligible for coverage under the ACA Medicaid expansion. Of these approximately 15.1 million newly Medicaid-eligible uninsured adults, 11.5 million have incomes below 100 percent of FPL and, therefore, would not receive any additional help obtaining health insurance coverage under the ACA if their state does not expand its Medicaid program.<sup>7</sup> This brief provides new information from the 2010 American Community Survey about who these

APPENDIX V

Robert Wood Johnson Foundation



Urban Institute

bills or said they were paying off medical debt.<sup>19</sup> While many young adults have benefited from the expansion of dependent coverage up to age 26, additional Medicaid coverage among this population could target young adults from lower-income backgrounds who are less likely to have parents with employer-sponsored coverage that could include them.<sup>20</sup>

Around two million uninsured adults who could gain Medicaid coverage under the ACA are between the ages of 55 and 64. Increased coverage among this group could not only increase their access to needed care but could also reduce future health care costs under Medicare: research suggests that lack of coverage before reaching Medicare eligibility at age 65 is associated with greater utilization and higher expenditures under Medicare.<sup>21</sup>

While just over half of the uninsured adults who could gain Medicaid coverage under the ACA are white, potential increases in coverage under the ACA could substantially reduce racial and ethnic differentials in health insurance coverage. With full implementation of the ACA, gaps in uninsurance rates between whites and Hispanics and between whites and blacks are expected to narrow, with potential attendant reductions in racial/ethnic differentials in access to health care and health outcomes.<sup>22</sup>

In addition, better addressing the health care needs of low-income adults could have other positive effects, given that so many who stand to gain coverage under the ACA Medicaid expansion are women of reproductive ages. Since Medicaid currently provides coverage for many women only when they are pregnant, the ACA Medicaid expansion has the potential to lead to better health in the

pre-conception period to increased spacing between births, and to improved birth outcomes and health of newborns. In addition, the increased health insurance coverage of both custodial and non-custodial parents should increase the extent to which their physical and mental health needs are addressed, and reduce the financial burdens they experience associated with health care. Benefits that accrue to adults should have positive effects on their children and families as well.<sup>23</sup>

Much of the discussion on expanding Medicaid under the ACA has focused on the fiscal implications for states: However, exclusively monetary calculations ignore the potential human, financial and productivity benefits associated with improved access to affordable health care for the millions of low-income adults who lack health insurance coverage and their families.

## Endnotes

- 1 The Medicaid eligibility threshold established under the ACA is 133 percent of FPL, to which a 5 percent disregard is applied; therefore, de facto, the Medicaid eligibility threshold under the ACA is 138 percent of FPL. Under the ACA, states are required to maintain Medicaid and CHIP eligibility thresholds for children through 2019. Therefore, eligibility for children under Medicaid/CHIP is not expected to be directly affected by the Supreme Court's ruling.
- 2 Hebertin M, Brooks T, Guyer J, et al. "Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2012.
- 3 Pear R. "In Health Care Ruling, Vast Implications for Medicaid." New York Times, June 15, 2012. <http://www.nytimes.com/2012/06/16/us/health-care-ruling-vast-implications-for-medicaid.html?pagewanted=all>.
- 4 Blavin F, Holahan J, Kenney GM, et al. "A Decade of Coverage Losses: Implications for the Affordable Care Act." Washington, DC: Urban Institute, 2012. <http://www.urban.org/health-policy/url.cfm?ID=412314>.
- 5 Ibid.
- 6 The status as of July 10, 2012 can be found here: <http://dl.ebmcdp.net/~advisoryboard/infographics/Where-the-States-Stand7/story.html>.
- 7 Kenney G, Dubay L, Zuckerman S, et al. "Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would not Be Eligible for Medicaid?" Washington, DC: The Urban Institute, 2012. <http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf>.

<http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf>.

- 8 These estimates indicate how many uninsured individuals would be newly eligible for Medicaid but do not indicate how many would actually enroll (see Holahan and Headen 2010 (endnote 12) for a discussion of behavioral responses).
- 9 These estimates are derived from the 2010 American Community Survey (ACS), an annual survey fielded by the U.S. Census Bureau. We use an augmented version of the ACS prepared by the University of Minnesota Population Center, known as the Integrated Public Use Microdata Sample (IPUMS), which uses the public use sample of the ACS and contains edits for family relationships and other variables (Ruggles S, Alexander TJ, Genadek K, et al. Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]. Minneapolis, MN: University of Minnesota, 2010). All estimates use weights provided by the U.S. Census Bureau. Coverage estimates reflect edits that adjust for the underreporting of Medicaid/CHIP and the overreporting of private non-group coverage on the ACS; edits are conducted if other information collected in the survey and simulated Medicaid eligibility status suggest a sample case's coverage has been misclassified. The universe is limited to non-institutionalized civilian adults ages 19 through 64 who are citizens or lawfully resident immigrants who have been in the country more than five years. Because the ACS does not contain sufficient information to determine whether an individual is a lawfully resident immigrant and therefore potentially eligible for Medicaid coverage, we impute documentation status for non-citizens (see Passel J and Cohen D. "A Portrait of Unauthorized Immigrants in the United States." Pew Hispanic Center, April 2009). Parental status

is defined according to whether the adult has a child age 18 or under living in their household who is their biological, adoptive, or stepchild. Race/ethnicity is categorized into four mutually exclusive groups: white non-Hispanic; black non-Hispanic; Hispanic; and other, which includes all other groups and those of multiple race groups.

Adults who would be newly eligible for Medicaid under the ACA are identified using a model developed by Victoria Lynch for the Robert Wood Johnson Foundation that (1) simulates current/pre-ACA eligibility for comprehensive Medicaid or Medicaid-equivalent benefits using the rules in place in mid-2010 and (2) simulates eligibility for expanded Medicaid coverage under the ACA. The model simulates current eligibility using available information for each state on their Medicaid eligibility guidelines, including income thresholds for a particular family size, the extent of income disregards, asset limits, immigration status, and other factors. The following eligibility pathways are modeled: Section 1115 Waiver; Section 1931; Aged/Blind/Disabled and SSI; Aged-out Foster Children; Medically Needy; and Relative Caretakers. The model does not account for potential changes in existing eligibility categories when the ACA goes into effect: when ACA regulations are finalized, changes to income methodologies or other changes in classifications of "current" eligibility could affect estimates of "new" eligibility (see Department of the Treasury, Internal Revenue Service, 26 CFR Part 301, RIN 1545-BK87, "Regulations pertaining to the disclosure of return information to carry out eligibility requirements for health insurance affordability programs." Washington, DC, 2012. <http://www.irs.gov/pub/irs-drop/reg-119632-11.pdf>).

**Appendix Table 8: Uninsured Adults Newly Eligible for Medicaid Under the ACA with Incomes Below 100% of FPL by Age/Sex and State (Numbers in 1000's)**

	Men 19 to 44		Women 19 to 44		Men 45 to 64		Women 45 to 64	
	Share	Number	Share	Number	Share	Number	Share	Number
<b>United States</b>	39.2%	4,502	29.7%	3,414	14.2%	1,630	16.9%	1,937
Alabama	36.9%*	94	31.3%	79	14.1%	36	17.7%	45
Alaska	39.7%	12	29.8%	9	13.5%	4	16.9%	5
Arizona	28.0%*	9	30.3%	10	15.4%	5	26.2%**	8
Arkansas	37.5%	63	34.1%*	57	13.8%	23	14.6%**	24
California	40.7%*	575	28.2%*	398	14.1%	199	17.1%	242
Colorado	42.6%*	69	23.9%*	39	15.4%	25	18.1%	29
Connecticut	43.7%*	31	23.9%*	17	15.1%	11	17.3%	12
Delaware	##	##	##	##	##	##	##	##
District of Columbia	42.5%	6	33.3%	5	15.2%	2	8.6%**	1
Florida	37.5%*	374	28.0%*	278	15.8%*	157	18.7%**	186
Georgia	38.3%*	196	33.4%*	178	13.4%	71	16.4%	88
Hawaii	44.3%	15	22.2%*	7	17.9%	6	15.5%	5
Idaho	37.6%	30	30.4%	24	16.4%	13	15.5%	12
Illinois	42.4%*	183	24.9%*	107	16.2%*	70	16.5%	71
Indiana	39.2%	113	32.9%*	95	14.1%	41	13.7%**	40
Iowa	42.2%	34	25.4%*	20	14.5%	12	17.9%	14
Kansas	40.0%	41	30.8%	32	12.0%	12	17.2%	18
Kentucky	36.6%	86	29.8%	67	13.2%	30	18.4%	41
Louisiana	33.5%*	87	35.2%*	92	13.4%	35	17.9%	47
Maine	38.2%	12	20.2%*	7	20.5%*	7	21.2%*	7
Maryland	43.4%*	62	25.4%*	36	14.9%	21	16.3%	23
Massachusetts	48.5%*	34	25.1%*	18	13.1%	9	13.3%**	9
Michigan	42.5%*	183	27.0%*	116	15.1%	65	15.4%**	66
Minnesota	45.2%*	47	26.8%	28	15.2%	16	12.9%**	13
Mississippi	37.7%	69	33.4%*	61	12.9%	24	18.0%	29
Missouri	37.3%	101	33.1%*	88	12.2%*	33	16.8%	45
Montana	28.8%*	13	27.4%	12	20.4%*	9	23.3%**	10
Nebraska	42.1%	24	30.1%	17	13.7%	8	14.1%	8
Nevada	35.5%*	45	32.0%	41	14.3%	18	18.0%	23
New Hampshire	35.7%	13	27.6%	10	18.3%	7	18.3%	7
New Jersey	39.4%	96	28.4%	70	14.7%	36	17.5%	43
New Mexico	38.7%	40	28.6%	29	15.6%	16	17.1%	18
New York	31.8%*	20	29.9%	18	11.7%	7	25.5%**	16
North Carolina	38.1%	167	29.5%	129	15.2%	67	17.2%	75
North Dakota	29.4%*	4	25.6%	4	19.0%	3	26.1%**	4
Ohio	41.8%*	186	25.5%*	113	15.5%*	69	17.3%	77
Oklahoma	38.6%	66	31.5%	54	13.9%	24	16.0%	27
Oregon	36.7%*	71	29.5%	57	15.4%	30	18.2%	35
Pennsylvania	39.9%	159	27.8%*	110	15.1%	60	17.2%	69
Rhode Island	44.8%*	14	24.7%*	8	14.0%	4	16.4%	5
South Carolina	39.7%	92	28.7%*	62	13.9%	32	19.8%**	46
South Dakota	34.9%	11	31.6%	10	16.7%	5	16.3%	5
Tennessee	40.8%	116	24.7%*	70	15.4%*	44	19.0%**	54
Texas	36.9%*	490	35.9%*	490	11.3%*	150	14.8%**	197
Utah	45.3%*	33	31.7%	23	11.6%	8	11.4%**	8
Vermont	##	##	##	##	##	##	##	##
Virginia	40.4%	109	30.3%	82	12.4%*	34	17.0%	45
Washington	43.1%*	102	27.2%*	84	14.0%	33	15.6%	37
West Virginia	36.7%	37	31.9%	32	12.0%*	12	19.5%*	20
Wisconsin	43.9%*	64	22.7%*	33	18.2%*	26	15.2%	22
Wyoming	30.3%*	6	36.3%	7	15.5%	3	17.8%	3

Notes: See table A notes. (\*) indicates share is statistically different from the rest of the nation at the 0.1(0.05) level.  
 ## indicates sample size is less than 30 observations, and has been suppressed.  
 Italicized estimates have standard errors that are greater than 30 percent of the estimate itself and should be interpreted with caution.



## State and Consumer Initiatives

April 5, 2013

# Ex-Felons Are About to Get Health Coverage

By Michael Ollove, Staff Writer

Newly freed prisoners traditionally walk away from the penitentiary with a bus ticket and a few dollars in their pockets. Starting in January, many of the 650,000 inmates released from prison each year will be eligible for something else: health care by way of Medicaid, thanks to the Affordable Care Act.

A sizeable portion of the nearly 5 million ex-offenders who are on parole or probation at any given time will also be covered.

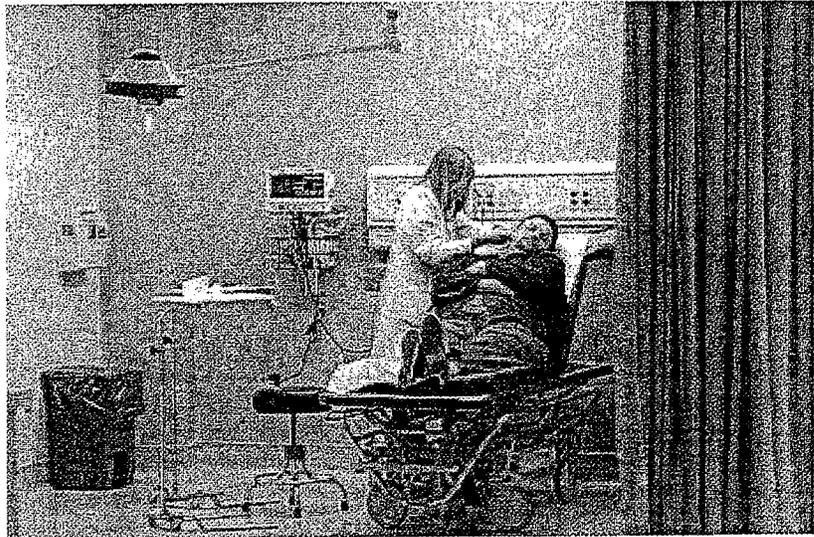
The expansion of Medicaid, a key provision of the health care reform law, is the main vehicle for delivering health insurance to former prisoners.

Researchers and those who advocate on behalf of ex-convicts hail the change as monumental, saying it will help address the generally poor health of ex-offenders, reduce medical costs and possibly keep them from sliding back into crime.

"It potentially revolutionizes the criminal justice system and health system," said Faye Taxman, a health services criminologist at George Mason University. "We now have a golden opportunity to develop and implement quality interventions to both improve health outcomes for this population and also reduce the rate of criminal activity."

### Expanding Coverage

Medicaid is the federal-state health insurance partnership for the poor. Under federal law, states must provide Medicaid to children, pregnant women and disabled adults who fall below certain income thresholds. The states are not now required to extend Medicaid to adults under 65 who are not pregnant or disabled. A small minority of states does so; most states do not.



Inmates get health care while they're in prison, such as this prisoner at San Quentin. Starting in January, ex-convicts will be eligible for health care provided through Medicaid. (AP)



# THE KAISER COMMISSION ON Medicaid and the Uninsured

ISSUE BRIEF

## What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care?

August 2013

SETTING THE RECORD STRAIGHT ON THE EVIDENCE

Medicaid, the nation's main public health insurance program for low-income people, now covers over 65 million Americans – more than 1 in every 5 – at least some time during the year. The program's beneficiaries include many of the most disadvantaged individuals and families in the U.S. in terms of poverty, poor health, and disability. The Affordable Care Act (ACA) provided for a broad expansion of Medicaid to cover millions of low-income uninsured adults whom the program has historically excluded. However, as a result of the Supreme Court's decision on the ACA, the Medicaid expansion is, in effect, a state option. Almost half the states are moving forward with the Medicaid expansion. But the others, which are home to half the uninsured adults who could gain Medicaid coverage under the ACA, have decided not to expand Medicaid at this time or are still debating the issue.

Controversy about the Medicaid expansion has been stoked by an assertion that first appeared in a *Wall Street Journal* editorial a couple of years ago and has since resurfaced periodically, that "Medicaid is worse than no coverage at all."<sup>1,2,3,4,5,6</sup> This claim about Medicaid is sharply at odds with the authoritative findings of the Institute of Medicine (IOM) Committee on Consequences of Uninsurance, detailed in *Care Without Coverage: Too Little, Too Late*, the second of six reports the IOM issued on the subject in the early 2000's.<sup>7</sup> Based on a comprehensive review of the research examining the impact of health insurance on adults, the IOM charted the causal pathway from coverage to better health outcomes, concluding:

Health insurance coverage is associated with better health outcomes for adults. It is also associated with having a regular source of care and with greater and more appropriate use of health services. These factors, in turn, improve the likelihood of disease screening and early detection, the management of chronic illness, and effective treatment of acute conditions such as traumatic brain injury and heart attacks. The ultimate result is improved health outcomes.

In light of Medicaid's large and growing coverage role, and the significant health care needs of its beneficiaries, an evidence-based assessment of the program's impact on access to care, health outcomes, and quality of care is of major interest. Such an assessment would also be helpful given perennial concerns about insufficient physician participation in Medicaid, generally attributed to low fees paid by state Medicaid programs. Since Medicaid was established nearly 45

APPENDIX X

- » *Medicaid improved adults' mental health markedly; Medicaid's impact on physical health remains inconclusive.* Objective clinical data collected on both groups of adults two years after the lottery show that, relative to being uninsured, having Medicaid led to a 30% reduction in the rate of positive screens for depression. Gains in physical health were more limited: while Medicaid did increase the detection of diabetes and use of diabetes medication, it did not have a statistically significant effect on diabetes control, or on control of high blood pressure or high cholesterol. The researchers note that their study lacked sufficient statistical power to detect changes, and many of their point estimates are, in fact, within the range of clinically meaningful changes that would be expected if Medicaid were effective. The authors also identify multiple factors that may mitigate the impact of coverage on clinical outcomes, including unmeasured barriers to access, missed diagnoses, inappropriate medication, patient noncompliance, and ineffectiveness of treatments.
- » *Medicaid virtually eliminated catastrophic medical expenses.* Catastrophic out-of-pocket spending (defined as costs exceeding 30% of income) was nearly eliminated among the adults who gained Medicaid coverage. Also, the likelihood of having medical debt was reduced by more than 20%, and having Medicaid had a significant impact on all self-reported measures of financial strain due to health care costs, including borrowing money or skipping other bills to pay medical bills and being refused treatment due to medical bills in the past six months.

Analyses that examine how Medicaid beneficiaries with serious chronic illnesses, such as diabetes, fare are of particular interest because of the prevalence of these conditions in the Medicaid population and the consequences if care is lacking. A recent series of studies focused specifically on low-income nonelderly adults with major chronic diseases shows statistically significant and clinically important differences between Medicaid beneficiaries and the uninsured on important measures of access and care. For example, adults with diabetes who are covered by Medicaid are less likely than those who lack insurance to report delaying or being unable to get needed care. They also have more office visits, fill more prescriptions, and are more likely to receive the key elements of recommended diabetes care.<sup>22</sup> The two related studies on other major chronic illnesses show similar results.<sup>23</sup>

Continuity in Medicaid coverage makes a difference. Research has shown that interruptions in Medicaid coverage can lead to greater emergency department use as well as significant increases in hospitalization for conditions that can be managed on an ambulatory basis.<sup>24,25,26</sup> Studies examining the short-term impacts of loss of Medicaid coverage provide additional evidence of Medicaid's impact. Studies in California and Oregon of low-income adults who lost their Medicaid coverage found significant declines in basic measures of access, such as having a USOC, unmet health care and medication needs, and likelihood of a recent primary care visit, as well as significant declines in health status.<sup>27,28</sup> In focus groups conducted with adult Medicaid beneficiaries in Massachusetts following the state's elimination of adult dental benefits, nearly all the participants reported serious oral health problems that, for many, resulted in chronic and serious pain.<sup>29</sup>

Beyond showing improved access to care and use of recommended care for Medicaid beneficiaries relative to the uninsured, research also provides evidence that broader eligibility for Medicaid at the state level is associated with significant reductions in both child mortality<sup>30</sup> and adult mortality.<sup>31</sup> A study examining the relationship between broader state Medicaid coverage of adults and access to physician and preventive services found that higher levels of Medicaid coverage were associated with substantially improved access to care for all low-income adults in the state, and also that access gaps between low- and high-income adults were substantially larger in states with limited Medicaid coverage than in states with broader coverage.<sup>32</sup>

## APPENDIX X

## SPECIAL ARTICLE

# Mortality and Access to Care among Adults after State Medicaid Expansions

Benjamin D. Sommers, M.D., Ph.D., Katherine Baicker, Ph.D.,  
and Arnold M. Epstein, M.D.

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 ABSTRACT
 

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## BACKGROUND

Several states have expanded Medicaid eligibility for adults in the past decade, and the Affordable Care Act allows states to expand Medicaid dramatically in 2014. Yet the effect of such changes on adults' health remains unclear. We examined whether Medicaid expansions were associated with changes in mortality and other health-related measures.

## METHODS

We compared three states that substantially expanded adult Medicaid eligibility since 2000 (New York, Maine, and Arizona) with neighboring states without expansions. The sample consisted of adults between the ages of 20 and 64 years who were observed 5 years before and after the expansions, from 1997 through 2007. The primary outcome was all-cause county-level mortality among 68,012 year- and county-specific observations in the Compressed Mortality File of the Centers for Disease Control and Prevention. Secondary outcomes were rates of insurance coverage, delayed care because of costs, and self-reported health among 169,124 persons in the Current Population Survey and 192,148 persons in the Behavioral Risk Factor Surveillance System.

## RESULTS

Medicaid expansions were associated with a significant reduction in adjusted all-cause mortality (by 19.6 deaths per 100,000 adults, for a relative reduction of 6.1%;  $P=0.001$ ). Mortality reductions were greatest among older adults, nonwhites, and residents of poorer counties. Expansions increased Medicaid coverage (by 2.2 percentage points, for a relative increase of 24.7%;  $P=0.01$ ), decreased rates of uninsurance (by 3.2 percentage points, for a relative reduction of 14.7%;  $P<0.001$ ), decreased rates of delayed care because of costs (by 2.9 percentage points, for a relative reduction of 21.3%;  $P=0.002$ ), and increased rates of self-reported health status of "excellent" or "very good" (by 2.2 percentage points, for a relative increase of 3.4%;  $P=0.04$ ).

## CONCLUSIONS

State Medicaid expansions to cover low-income adults were significantly associated with reduced mortality as well as improved coverage, access to care, and self-reported health.

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## APPENDIX Y

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The New England Journal of Medicine

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# DYING FOR COVERAGE

The Deadly Consequences of  
Being Uninsured

Table 2.  
Deaths Due to a Lack of Health Coverage, 25- to 64-Year-Olds, by State,  
2005-2010

State	Total Deaths, 2005-2010	State	Total Deaths, 2005-2010
Alabama	2,668	Montana	483
Alaska	344	Nebraska	480
Arizona	3,417	Nevada	1,504
Arkansas	1,998	New Hampshire	339
California	16,285	New Jersey	2,980
Colorado	1,652	New Mexico	1,404
Connecticut	825	New York	6,481
Delaware	314	North Carolina	4,843
DC	290	North Dakota	179
Florida	12,336	Ohio	4,496
Georgia	5,624	Oklahoma	2,424
Hawaii	289	Oregon	1,687
Idaho	551	Pennsylvania	3,778
Illinois	4,946	Rhode Island	276
Indiana	2,458	South Carolina	2,927
Iowa	777	South Dakota	240
Kansas	875	Tennessee	3,483
Kentucky	2,298	Texas	15,435
Louisiana	3,346	Utah	687
Maine	398	Vermont	154
Maryland	2,075	Virginia	2,706
Massachusetts	*	Washington	2,069
Michigan	3,584	West Virginia	1,223
Minnesota	846	Wisconsin	1,204
Mississippi	2,289	Wyoming	248
Missouri	2,515	U.S. Total	134,120

Source: Families USA calculations based on estimates by the Institute of Medicine.

\* Massachusetts data are not reportable because they do not reflect the state's health reform program.

Table 3 cont'd.

Deaths Due to a Lack of Health Coverage, 25- to 64-Year-Olds,  
By State, 2010

State	Deaths Per Week	Deaths Per Month	Total Deaths, 2010
Nevada	6	27	320
New Hampshire	1	5	61
New Jersey	11	49	583
New Mexico	5	21	251
New York	24	104	1,247
North Carolina	18	78	931
North Dakota	1	3	36
Ohio	17	76	907
Oklahoma	9	38	452
Oregon	6	24	293
Pennsylvania	14	62	745
Rhode Island	1	5	56
South Carolina	12	52	625
South Dakota	1	4	46
Tennessee	12	53	633
Texas	57	246	2,955
Utah	2	11	126
Vermont	**	2	28
Virginia	11	48	574
Washington	8	35	419
West Virginia	4	19	223
Wisconsin	5	22	270
Wyoming	1	4	51
<b>U.S. Total</b>	<b>502</b>	<b>2,175</b>	<b>26,100***</b>

Source: Families USA calculations based on estimates by the Institute of Medicine.

\*Massachusetts data are not reportable because they do not reflect the state's health reform program.

\*\*One Vermonter dies every two weeks due to lack of health coverage.

\*\*\* Total does not add due to rounding.

### The uninsured often delay or forgo needed medical care.

- Uninsured adults are more than six times as likely as privately insured adults to go without needed care due to cost (26 percent versus 4 percent).<sup>9</sup>
- Cancer patients without health insurance are more than five times more likely to delay or forgo cancer-related care because of medical costs than insured patients (27 percent versus 5 percent).<sup>10</sup>

### Uninsured Americans are sicker and die earlier than those who have insurance.

- Uninsured adults are more likely to be diagnosed with a disease in an advanced stage. For example, uninsured women are substantially more likely to be diagnosed with advanced stage breast cancer than women with private insurance,<sup>11</sup> as are uninsured people with colorectal cancer.<sup>12</sup>
- Uninsured adults are at least 25 percent more likely to die prematurely than adults with private health insurance.<sup>13</sup>

### The uninsured pay more for medical care.

- Uninsured patients are unable to negotiate the discounts on hospital and doctor charges that insurance companies do. As a result, uninsured patients are often charged more than 2.5 times what insured patients are charged for hospital services.<sup>14</sup>
- Three out of five uninsured adults (60 percent) under the age of 65 report having problems with medical bills or medical debt.<sup>15</sup>