

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.	:	
	:	
THE STATE OF OHIO CONTROLLING	:	
BOARD et al.,	:	
	:	
Respondents.	:	

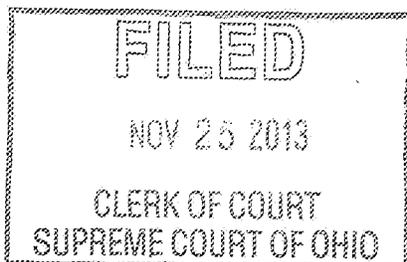
**AMICUS CURIAE BRIEF OF THE OHIO NATIONAL GUARD ASSOCIATION,
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ASSOCIATION OF COMMUNITY HEALTH CENTERS, THE OHIO
MANUFACTURERS ASSOCIATION, THE OHIO RIGHT TO LIFE SOCIETY, THE
COLUMBUS CHAMBER OF COMMERCE, PHILANTHROPY OHIO, THE DAYTON
CHAMBER OF COMMERCE, THE CINCINNATI USA REGIONAL CHAMBER OF
COMMERCE AND THE OHIO ASSOCIATION OF HEALTH PLANS
IN SUPPORT OF RESPONDENTS THE STATE OF OHIO CONTROLLING BOARD
AND THE OHIO DEPARTMENT OF MEDICAID**

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I. INTRODUCTION

Amici Curiae support the Respondents and urge this Court to deny the Relators' request for a writ of mandamus. The Relators refer to Medicaid expansion as "the equivalent of a ticking time-bomb for Ohio's budget" and claim that Medicaid expansion "would dramatically alter the provision of health care and health care coverage in Ohio." Nothing could be further from the truth.

To the contrary, as Governor Kasich recently succinctly and accurately summarized, Medicaid expansion is about bringing Ohio money home to Ohio and back from Washington D.C. Medicaid expansion will return nearly \$14 billion in Ohio taxpayer money to the Buckeye State; \$14 billion that will otherwise be sent to fund Medicaid expansion in other states, leaving Ohioans with nothing in return for their hard-earned tax dollars. Ohio's Medicaid expansion funds will also be wisely and efficiently spent. Under Governor Kasich's Office of Health Transformation, Ohio Medicaid has become the envy of state-run Medicaid programs, receiving national recognition for being at the forefront of achieving dramatic improvements in care coordination and managed care outcomes for patients while simultaneously modernizing the program and significantly reducing the costs of plan administration. The Relators' attempt to portray Medicaid expansion as a run-away spending program in Ohio is not supported by the facts.

Moreover, Medicaid expansion, fully funded by federal dollars, does not "dramatically alter" the provision of Medicaid, but rather simply extends current Medicaid benefits to those adults between 100% and 138% Federal Poverty Level ("FPL"). This translates to \$15,000.00 per year for a single adult and \$32,000.00 per year for a family of four. Medicaid expansion will thus directly benefit the most vulnerable working poor in Ohio who are in the unfortunate

position of making just slightly too much to currently qualify for Medicaid, but not enough to afford health insurance and quality and consistent healthcare. This is particularly true for the thousands of Ohioans battling mental health issues and addiction who, under Medicaid expansion, will at last get the kind of care they so desperately need. Medicaid expansion gives a key segment of Ohio's population the opportunity to share in Ohio's economic growth and take the first steps to a better and healthier future.

While the Director of Medicaid's decision to expand Medicaid is not at issue in this case, the ability to obtain the federal dollars to fund such expansion is. The Relators intend to prevent the lawful funding of Medicaid expansion in Ohio: funding that truly betters every Ohio citizen. To this end, this Amicus Brief will focus on the myriad benefits of Medicaid expansion funding in Ohio, all of which will be lost if the Relators obtain the relief sought -- relief to which they are not entitled under Ohio law.

II. STATEMENT OF THE IDENTITY AND INTEREST OF AMICI

Amici are Ohio organizations dedicated in whole or in part to the improvement of health outcomes for all Ohio citizens, including Ohio Medicaid recipients. Amici are also deeply concerned about the growth and expansion of the Ohio economy and the effective and efficient operation of the various health care systems in Ohio. Amici support the Respondents in this action because, if this Court were to grant the relief requested by the Relators, such ruling would prevent the lawful federal funding of Medicaid expansion in Ohio, have a profound impact on the health of Ohio's most vulnerable citizens, and prevent all Ohioans from receiving the social and economic benefits Medicaid expansion will provide.

The Ohio National Guard Association promotes, protects and defends the vital interests of the Ohio National Guard and its membership in Federal, State and Local Government. The

organization is comprised of volunteers dedicated to protecting and defending the basic values that all Americans cherish, as embodied in the United States Constitution and demonstrated by their members' commitment to the Minutemen tradition of selfless dedication to Community, State and Nation.

Sheriff Gene A. Kelly has been the sheriff of Clark County, Ohio since 1987.

The Ohio Association of Community Health Centers ("OACHC") is a not-for-profit professional trade association representing Ohio's Federally Qualified Health Centers (FQHCs, or Community Health Centers). OACHC represents 41 Ohio Community Health Centers at over 200 locations in 47 of Ohio's 88 counties. OACHC supports access to high-quality, affordable health care through the growth and development of Ohio's Community Health Centers.

The Ohio Manufacturers Association is a statewide association of approximately 1,600 manufacturing companies, which collectively employ the majority of the 610,000 men and women who work in manufacturing in the state of Ohio and account for almost 17% of Ohio's gross domestic product. Member companies are engaged in various businesses or industries in Ohio and are incorporated and/or conduct substantial business operations in the state.

The Ohio Right to Life Society is a state-wide, non-profit and non-sectarian advocacy organization dedicated to promoting and defending the rights of the unborn, the elderly and those suffering from chronic and terminal illnesses. The Ohio Right to Life Society has as among its goals ensuring that each person's individual rights under the law are protected, including, but not limited to, with regard to healthcare and associated treatments and procedures. Further, The Ohio Right to Life Society believes low-income women should have access to a primary care physician to receive quality healthcare.

The Columbus Chamber of Commerce is a non-profit organization providing businesses and organizations opportunities to tap into valuable resources designed to promote and support businesses of all sizes throughout the Columbus region. It represents the interests of 2,000 member businesses and their 268,000 employees.

Philanthropy Ohio is an association of foundations, corporate giving programs, individuals and organizations actively involved in philanthropy in Ohio. Its mission is to provide leadership for philanthropy throughout Ohio and to enhance the ability of members to fulfill their charitable goals.

The Dayton Chamber of Commerce is a non-profit organization providing businesses and organizations opportunities to tap into valuable resources designed to promote and support businesses of all sizes throughout the Dayton region. It represents the interests of 2,700 member businesses across nine Ohio counties.

The Cincinnati USA Regional Chamber of Commerce is a non-profit organization providing businesses and organizations opportunities to tap into valuable resources designed to promote and support businesses of all sizes throughout the greater Cincinnati area. It represents the interests of 5,000 member businesses.

The Ohio Association of Health Plans (“OAHP”) is a non-profit association comprised of health plans who collectively provide health insurance coverage to more than 7.5 million Ohioans. The OAHP is a leading organization in actively promoting and advocating for quality healthcare and healthcare benefits for all Ohioans.

III. ARGUMENT

Proposition of Law:The State Of Ohio Controlling Board Was Authorized To Approve The Ohio Department Of Medicaid's Appropriation Request.

A. The Controlling Board Properly Exercised Its Authority Under Ohio Law In Approving The Ohio Department Of Medicaid's Appropriation Request.

The version of H.B. 59 which actually became Ohio law, relevant portions of which are now codified in Chapters 5162 and 5163 of the Ohio Revised Code, expressly authorizes the Director of the Ohio Department of Medicaid to decide, in his discretion, to cover “optional eligibility groups,” including those persons eligible under Medicaid expansion. *See Ohio Rev. Code §5163.03(C)*. The limitation on the Director’s discretion is if another Ohio statute prohibits the extension of coverage to the “optional eligibility group” at issue. *Id.* Importantly, no Ohio statute prohibits those eligible under Medicaid expansion from being covered. *Id.* If the Department of Medicaid decides to expand Medicaid coverage, as it has here, Ohio Revised Code §5162.07 authorizes the Director to seek from the federal government an “amendment to the Medicaid state plan...for all components, and aspects of components, of the Medicaid program.” *See Ohio Rev. Code §5162.07.*

In full compliance with these statutes, the Director sought and obtained an amendment from the federal Centers for Medicare and Medicaid Services to expand Medicaid and receive the federal funds to do so. The Director’s decision in this regard is not at issue in this case. The Director of Medicaid then sought and received approval from the Ohio Controlling Board to spend those federal funds on Medicaid expansion. The Controlling Board’s decision is squarely at issue here.

The Ohio Controlling Board was well within its authority to approve the Department of Medicaid’s request. Section 131.35 of the Ohio Revised Code expressly authorizes any state

agency to obtain Ohio Controlling Board authorization “to make expenditures of any federal funds.” *See Ohio Rev. Code §131.35(A)(1)*. Furthermore, “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.” *See Ohio Rev. Code §131.35(A)(5)*.

The Controlling Board’s decision to approve the Department of Medicaid spending federal funds on Medicaid expansion did not violate Ohio Revised Code §127.17, because such decision was not contrary to any prevailing appropriation act. *See Ohio Rev. Code §127.17* (Emphasis added).

The Relators rely solely on the portion of H.B. 59 which contained the phrase “The Medicaid program shall not cover the group described in the Social Security Act, section 1902(a)(10)(A)(i)(VIII), 42 U.S.C. 1396(a)(10)(A)(i)(VII).” However, this provision was line-item vetoed by Governor Kasich. Under the Ohio Constitution, any provision of an appropriation bill vetoed by the Governor “shall be void, unless re-passed in the manner herein prescribed for the re-passage of a bill.” *See Section 16, Article II, Ohio Constitution*. Simply put, the provision relied upon by the Relators is void and of no effect under the Ohio Constitution, is not enacted Ohio law, and thus is not a prevailing appropriation act. *Id.*

The improper relief sought by the Relators would allow 6 members of the 132-member general assembly to override a veto by a sitting Ohio Governor. *Id.* In so doing, the Relators would limit the Ohio Controlling Board’s authority based solely upon a single sentence vetoed from an appropriation bill, and which is therefore expressly void under the Ohio Constitution. *Id.* The Relators’ requested relief is contrary to Ohio statutory law, contrary to the Ohio Constitution, and contrary to the checks and balances governing the legislative process in Ohio.

The Ohio Controlling Board is under no duty whatsoever, let alone a clear public duty, to deny the Department of Medicaid the ability to spend federal funds because six members of the general assembly want that result. Rather, such a decision is within the sound authority and discretion of the Ohio Controlling Board. The Relators have no right, let alone a clear public right, to have this Court order the Ohio Controlling Board to reach a different decision.

The Relators' request for a writ of mandamus must be denied. Amici herein join in and support the Brief filed in this case by Respondents, The Ohio Controlling Board and The Ohio Department of Medicaid, and in the Briefs of the other Amici Curiae filed in support of the Respondents.

B. Granting The Relief Sought By The Relators Will Negatively Impact The State Of Ohio By Preventing Medicaid Expansion Funding.

The relief sought by the Relators will bring the ongoing process of funding Ohio Medicaid expansion to an abrupt and unfortunate end. Absent Medicaid expansion, hundreds of thousands of Ohio's working poor, particularly parents with minor children, veterans, and those desperately in need of mental health and addiction treatment, will be left without access to the healthcare they need. Ohio hospitals and physicians will be under further strain of providing uncompensated care, while simultaneously not receiving billions of dollars in otherwise available Medicaid payments.

The State of Ohio and local governments will lose out on \$2.7 - \$2.8 billion in Medicaid expansion-generated revenues, while at the same time losing well over a billion dollars in potential savings stemming from new Medicaid spending. *See* Health Policy Institute of Ohio, The Ohio State University, Regional Economic Modeling, Inc., and the Urban Institute, Expanding Medicaid in Ohio, Analysis of Likely Effects (March 2013) ("Ohio Medicaid Expansion Study") (Appendix at 22). Ohio's small businesses and employers will be burdened

with millions of dollars in penalties and exponential increases in the costs of insuring their employees. *See* Brian Haile, *The Supreme Court's ACA Decision and its Hidden Surprise for Employers*, Jackson Hewitt Tax Services, Inc. (March 13, 2012) (Appendix at 25). And, Ohio's criminal justice system will suffer, as prisoners and high-risk young adults fail to receive the mental health and addiction treatments and medications required to help them beat the cycle of crime and imprisonment. *See* Testimony of Sheriff Michael Heldman before the House Finance Committee of the Ohio General Assembly (August 27, 2013) (Appendix at 31). All of Ohio loses if the Relators win and Medicaid expansion funding is prevented.

1. Overview Of Ohio Medicaid Expansion.

Medicaid expansion extends the scope of individuals eligible to receive Medicaid in Ohio. Medicaid expansion does not substantially alter the benefits provided by the program, but rather expands the definition of persons within the program's covered-population. Under the current eligibility guidelines, Medicaid serves approximately 2 million Ohioans. *See* Health Policy Institute of Ohio, *Ohio Medicaid Basics 2013* (March 2013) ("HPIO") (Appendix at 32). Absent expansion, only the following Ohioans will continue to qualify for Medicaid coverage: (1) children and pregnant women in households earning below 200% FPL; (2) adult parents earning below 90% FPL; (3) disabled individuals earning below 64% of FPL (or earning below 250% FPL, if working); and (4) low-income senior citizens only to the extent they have qualifying nursing home care expenses. *See* Ohio Medicaid Expansion Study (Appendix at 1).

Under Medicaid expansion, all adults, whether or not they have children, qualify for Medicaid coverage if their earnings are below 138% FPL (approximately \$15,000.00 per year for a single adult and approximately \$32,000.00 for a family of four). *See* HPIO (Appendix at 33 & 47). Through this change in the definition of covered population, Medicaid expansion will

immediately open up eligibility to approximately 275,000 more Ohioans, most of whom are currently uninsured and/or underinsured. *See* Greg Moody, Health Transformation Budget Priorities, testimony before the House Finance Committee of the Ohio General Assembly (February 14, 2013) (“Moody Testimony”) (Appendix at 55). And, a recent study conducted by The Ohio State University and The Urban Institute estimates that over 450,000 currently uninsured Ohioans will gain coverage through Medicaid expansion by 2022. *See* Ohio Medicaid Expansion Study (Appendix at 14).

Medicaid expansion is funded with federal tax dollars that Ohioans are already sending each year to Washington D.C. Through 2016, 100% of non-administrative costs and expenses associated with Medicaid expansion will be funded by the federal government through payments received from the federal Centers for Medicare and Medicaid Services. *See id.* (Appendix at 5). Thereafter, the federal government will continue to fund at least 90% of non-administrative costs and expenses associated with Medicaid expansion. *See id.* The 90% federal funding figure is fixed by federal statute. *See id.* The administrative costs of Medicaid expansion will be shared equally between Ohio and the federal government, as is the case with regard to administrative costs under Medicaid currently. *See id.* (Appendix at 6). If Ohio does not participate in Medicaid expansion, Ohio Medicaid tax dollars will go to cover citizens in other states instead. *See* Governor’s Office of Health Transformation, Coverage Saves Jobs (September 30, 2013) (Appendix at 102)(available at <http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=pyzZGSrppM4%3d&tabid=160>).

Medicaid expansion is also designed to work hand-in-hand with the federal health insurance subsidy program. Under this program, the federal government provides adults

between 100% and 400% FPL with subsidies toward the payment of private health insurance premiums if those adults either do not qualify for Medicaid coverage or do not have affordable coverage through their respective employers. *See* American Academy of Actuaries, Implications of Medicaid Expansion Decision on Private Coverage (September 2012) (Appendix at 107) (*available at* http://www.actuary.org/files/Medicaid_Considerations_09_05_2012.pdf). By extending Medicaid coverage to all adults below 138% FPL, fewer dollars will be required to fund and operate the subsidy program. *See* Ohio Medicaid Expansion Study (Appendix at 14). In a related note, absent expansion, unlike adults between 100% and 138% FPL, non-Medicaid eligible adults below 100% FPL cannot participate in the subsidy program. *See* Medicaid Expansion Study (Appendix at 1). This is because federal law anticipated these individuals would instead be covered by Medicaid and not need the subsidies. *See id.* Not expanding Medicaid in Ohio would thus create an unfortunate situation where the very poorest adults would be unable to secure healthcare coverage of any kind. *See id.*

In addition, Ohio's Medicaid reforms over the past two years have been nationally recognized for leading to improved care coordination, improved health outcomes and reduced overall operating costs. *See* Coverage Saves Jobs (Appendix at 102). These reforms leave Ohio perfectly placed to successfully expand Medicaid coverage now in a way that will cover more people, provide higher quality care to those covered, and create a greater overall value to the taxpayers who fund the program.

2. Medicaid Expansion Creates Ohio Jobs And Grows Ohio's Economy.

The recent Ohio Medicaid Expansion Study concluded that Medicaid expansion will drive significant increases in Ohio employment and Ohio earnings over the next decade. *See* Ohio Medicaid Expansion Study (Appendix at 15). The job creation and earnings expansion will

be fueled by the influx of additional federal dollars paying for health care in Ohio, which will be unavailable absent Medicaid expansion. *See id.* The study concluded that Medicaid expansion will create over 30,000 Ohio jobs between 2014 and 2022, bringing over \$17.5 billion in additional earnings to the Buckeye State. *See id.* (Appendix at 16). And, states that adopt Medicaid expansion will otherwise have inherent hiring advantages, as their employers will not need to underwrite the cost of healthcare for their Medicaid-eligible employees. As such, Medicaid expansion will prevent Ohio employers from being competitively disadvantaged, thus preserving and expanding the availability of quality Ohio job opportunities. The failure of Medicaid expansion will thus cost Ohio valuable jobs, employees and employers.

3. Medicaid Expansion Assists Ohio Small Businesses And Employers.

Medicaid expansion also provides many vital benefits and protections to Ohio businesses, all of which will be lost if the Relators obtain the relief sought and halt Medicaid expansion funding in its tracks. As an initial matter, absent Medicaid expansion, Ohio businesses and their employees will see a significant increase in the cost of private health insurance premiums. *See Ohio Medicaid Expansion Study* (Appendix at 16). The Congressional Budget Office estimates an average 2% annual increase in private insurance premiums should Medicaid expansion fail. *See Implications of Medicaid Expansion Decision on Private Coverage* (Appendix at 107). The 2% increase stems from those adults under 138% FPL, who would otherwise be Medicaid eligible under expansion, remaining in the private health insurance market. *See id.* Due to their history of not receiving regular healthcare in the past, these individuals are likely to have higher healthcare needs and costs, which will then be passed on to other Ohio consumers and businesses. *See id.*

Similarly, in its 2013 study, the Urban Institute concluded that, if Medicaid expansion were to fail, Ohio employers will incur an estimated \$1.7 billion increase in healthcare-related costs between 2014 and 2022. *See* Ohio Medicaid Expansion Study (Appendix at 17). The Urban Institute estimated an additional \$7.4 billion increase in private-market consumer healthcare costs absent expansion. *See id.*

In addition, Ohio employers with 51 or more full-time employees are subject to penalties if an employee goes outside of the employer's plan and instead purchases their own health insurance through the previously mentioned private market health insurance subsidy program (for adults between 100% and 400% FPL). *See* The Supreme Court's ACA Decision and its Hidden Surprise for Employers (Appendix at 26-30). These penalty and subsidy provisions were enacted under the assumption that Medicaid expansion would be passed in Ohio. *See id.* (Appendix at 25). As such, without expansion, many Ohio workers who would have otherwise qualified for Medicaid will instead participate in the subsidy program, and in so doing cause their employers to incur potentially significant penalties. *See id.* (Appendix at 26-30). A study by Jackson Hewitt concluded that, absent Medicaid expansion, Ohio employers will pay approximately \$88 million in such penalties when the penalty provisions are fully implemented. *See id.* (Appendix at 29).

As such, absent Medicaid expansion, Ohio employers not only lose out on the benefits of job creation, healthier, happier and more productive employees, and an expanded and more competitive labor market, they also face stiff penalties and the prospect of exponential health insurance premium increases. Medicaid expansion is in the best interests of Ohio businesses, large and small, and their employees.

4. Medicaid Expansion Increases State Revenues And Provides Budget Savings.

Medicaid expansion also benefits Ohio by significantly increasing State tax revenues, while simultaneously reducing State expenditures on certain healthcare-related items. This results in a \$1.8 billion net gain to the State, which can be allocated to tax cuts and/or increased spending in other key areas that benefit all Ohioans, such as education and infrastructure improvements. *See Ohio Medicaid Expansion Study (Appendix at 21).*

On the revenue side, Medicaid expansion is estimated to produce a \$1.7 billion increase in tax revenue from 2014 through 2022, stemming from increased federal spending on premiums to Medicaid managed care companies, which are now subject to a 5.75% Ohio sales tax and a 1.0% state health insurance tax (of note, the \$1.7 billion estimate was based on the previous lower Ohio sales tax rate of 5.5%). *See id.* (Appendix at 11). During this same time period, an additional \$857 million in revenue will be generated through sales tax collections on goods and services purchased by Ohio hospitals, doctors, dentists and other providers using the federal Medicaid expansion dollars they receive. *See id.* (Appendix at 12). Ohio will further receive approximately \$218 million in prescription drug rebates from pharmaceutical companies participating in expanded Ohio Medicaid. *See id.* (Appendix at 13). Medicaid expansion will therefore generate almost \$2.8 billion in additional State revenues over the next decade.

Similarly, on the cost side, Medicaid expansion will significantly decrease State spending on healthcare-related items that will instead be covered by Medicaid. The Ohio Medicaid Expansion Study concluded that, as a result of Medicaid expansion, Ohio will save \$709 million it would otherwise have paid toward healthcare costs of adults who instead receive expanded Medicaid coverage. *See id.* (Appendix at 7). The State will save approximately \$48 million related to breast and cervical cancer treatments for women that will instead be covered by

Medicaid. *See id.* \$273 million in Ohio savings will come from Ohio prisoners being almost universally qualified for Medicaid, with another \$389 million in savings stemming from additional adult mental health and addiction treatments becoming Medicaid-covered. *See id.* (Appendix at 9).

As such, Medicaid expansion means a net gain for Ohio of over \$4 billion over the next decade. *See id.* (Appendix at 12). Even factoring in the estimated \$2.5 billion increase to the State during this time period for costs associated with funding and administering Medicaid expansion, the State comes out over \$1.6 billion ahead. *See id.* (Appendix at 20-22). However, if Medicaid expansion funding fails – which is what the Relators seek in this case – that billion dollar gain, and all of its associated benefits, are forever lost.

5. Medicaid Expansion Protects Ohio Healthcare Providers.

Ohio hospitals are required by law in many cases to provide care even if the patient lacks insurance and/or otherwise is unable to pay for treatment. *See* HPIO (Appendix at 43). Uncompensated care for these patients cost Ohio hospitals over \$1.2 billion in 2012 alone. *See* Coverage Saves Jobs (Appendix at 104). Currently, Ohio hospitals receive some protection from these losses through the federal “disproportionate share hospital program,” or “DSH.” *See* HPIO (Appendix at 43). The DSH program provided \$356 million to Ohio hospitals in 2012 to help off-set the losses from uncompensated care. *See* Coverage Saves Jobs (Appendix at 104). However, recent amendments to the Medicaid program reduce the DSH program, and Medicaid expansion was designed, in part, to fill in the gap caused by the reduction in DSH subsidies. *See* Moody’s Investors Service, Medicaid and Medicare DSH payment reductions could challenge states and hospitals (March 14, 2013) (Appendix at 110).

If Ohio does not participate in Medicaid expansion, hospitals will be forced to absorb 100% of uncompensated care costs, or ultimately shift them to insured patients or private payers, increasing overall costs to consumers and to businesses that provide health insurance to their employees. See Excerpts from Institute of Medicine: America's Uninsured Crisis, Consequences for Health and Health Care (Appendix at 137-138) (available at http://www.nap.edu/catalog.php?record_id=12511). The failure of Medicaid expansion, coupled with loss of the full DSH program, will impact rural and safety net hospitals the most, as these facilities tend to treat the largest number of patients without insurance (and who also often have more severe conditions stemming from lack of regular care). See Kaiser Health News, "Rural Poor Likely to Feel the Pinch of State Decisions Not to Expand Medicaid" (September 3, 2013) (Appendix at 139-140) (available at <http://www.kaiserhealthnews.org/daily-reports/2013/september/03/medicaid-expansion.aspx>).

Many of these rural and safety net hospitals may ultimately not be able to continue operations absent Medicaid expansion. See Bloomberg News, "Hospitals Brace as Republicans Fight Over Medicaid" (September 19, 2013) (Appendix at 141-144) (available at <http://www.bloomberg.com/news/2013-09-19/hospitals-brace-as-republicans-fight-over-medicaid.html>). In addition, as previously discussed, expanded Medicaid provides more regular and cost-effective care for patients, meaning less uncompensated and expensive hospital and emergency room visits in the first place.

Along these lines, Medicaid expansion specifically benefits safety net providers such as Community Health Centers ("CHC"). These benefits in many cases flow to all patients, not just those on Medicaid. Medicaid expansion funding provides the investment necessary to increase the number of CHC locations, extend hours of operation, and provide higher staffing levels for

clinicians and other personnel. As such, Medicaid expansion creates more CHC employment opportunities in areas in desperate need of job growth. Expanded CHC capacity also keeps patients out of more costly settings such as emergency rooms and hospitals. Additional Medicaid funding will further improve patient-to-clinician ratios across all specialties, shortening wait times and generating a greater range of specialized care, such as oral and behavioral health services, that are frequently in short supply in Ohio's medically underserved communities.

A failure to expand Medicaid will also prevent Ohio providers from experiencing billions of dollars in additional revenues. Estimates show that Ohio providers will receive over \$13 billion in new federal spending for health care from Medicaid expansion during the next seven years, including \$5.9 billion to Ohio hospitals, \$2 billion to Ohio doctors, and \$1.4 billion to Ohio dentists. *See* Moody Testimony (Appendix at 55) and Coverage Saves Jobs (Appendix at 102). These additional revenues will preserve and create new jobs and keep vital Ohio hospitals and doctors open for business. The revenues will not happen, however, if the Relators are successful in blocking Medicaid expansion funding. And, importantly, preventing Medicaid expansion funding in Ohio will not save federal tax dollars (including tax dollars from Ohio) from being spent – those dollars will simply be spent in states other than Ohio. The Amicus Brief of The Ohio Hospital Association, The Ohio State Medical Association, and The Ohio Osteopathic Association further details the detrimental impact on Ohio providers should Medicaid expansion funding fail.

6. Medicaid Expansion Relieves Strains On Local Governments.

Medicaid expansion also benefits local governments in Ohio, many of which are already experiencing difficulties passing and renewing operating levies and otherwise balancing budgets without cutting programs vital to their constituents. To this end, similarly to the increased State

revenues previously discussed, economic activity associated with Medicaid expansion is expected to increase county sales tax revenue by nearly \$400 million from 2014 through 2022. *See* Ohio Medicaid Expansion Study (Appendix at 18). In addition, Medicaid expansion is expected to result in statewide county savings by covering mental health and/or addiction treatments currently paid for through local county levies. *See id.* (Appendix at 16-17). These savings can be used by Ohio counties on other social services needs important to their constituents.

7. Medicaid Expansion Provides Immediate Access To Healthcare And Improved Health Outcomes For Nearly 300,000 Ohioans.

a. Impact On Ohio's Working Poor.

Coupled with the other Medicaid reforms recently implemented, Medicaid expansion in Ohio can serve to ladder Ohio's adult working poor up and out of poverty. These individuals comprise one of the most vulnerable segments of the State's population, and include many adults currently working in the Medicaid field but who are not Medicaid-eligible. Medicaid expansion will immediately apply to cover 275,000 additional individuals in this category in 2014, and cover over 450,000 persons by 2022. *See* Ohio Medicaid Expansion Study (Appendix at 14). These individuals would otherwise be underinsured or, in many cases, be entirely without healthcare coverage whatsoever. *See id.*

75% of uninsured Ohioans work, but due to their lack of consistent and quality medical treatment, they tend to "live sicker and die younger" on average than their insured Ohio counterparts. *See* Coverage Saves Jobs (Appendix at 102). Moreover, uninsured working adults often delay seeking medical treatment until their medical conditions have significantly deteriorated, leading to higher healthcare costs and reduced health outcomes. *See* Institute of Medicine, America's Uninsured Crisis, Consequences for Health and Health Care (Appendix at

117-119). If the uninsured patient is required to pay these healthcare costs without insurance, the result is crippling debt and, in many cases, bankruptcy. Otherwise, these costs are born by the hospitals and providers themselves, or passed on indirectly to insured patients. In contrast, working adults with healthcare coverage are more likely to receive routine and timely care, thus avoiding illness and/or major medical procedures in the first place. *See id.* (Appendix at 119). Insured working adults are also more likely to receive more efficient and less costly healthcare through regular providers, such as a family doctor, rather than seeking treatment through urgent care and/or emergency room visits. *See id.*

The positive impact of expanded Medicaid eligibility on adults is well documented. A recent study published by the New England Journal of Medicine concluded that, with regard to three states that expanded their Medicaid coverage since 2000 (New York, Maine and Arizona), these states saw a 6.1% mortality reduction compared to non-expansion states. *See New England Journal of Medicine, Mortality and Access to Care Among Adults after State Medicaid Expansions* (September 13, 2012) (Appendix at 145). In these three states, Medicaid expansion decreased the percentage of uninsured adults by 15%, decreased rates of patients delaying seeking care by 21%, and increased the rates of self-reported health statuses of “excellent” or “very good” by 3.4%. *See id.*

Another recent study on the effects of Medicaid expansion in Oregon concluded that the rate of depression found in individuals who became newly eligible for Medicaid dropped by 30%. *See New England Journal of Medicine, The Oregon Experiment – Effects of Medicaid on Clinical Outcomes* (May 2, 2013) (Appendix at 157). The Oregon study also found that the use of catastrophic medical treatments was virtually eliminated for those Medicaid eligible, as compared to their uninsured counterparts. *See id.* (Appendix at 160).

In short, expanding healthcare coverage to the state's adult working poor is critical to promoting healthier, happier and more productive working adults, reducing overall healthcare costs, and providing the stabilized financial foundation necessary for these individuals to build the job skills that lead to wealth generation and greater economic independence.

b. Impact On Ohio Families And Children.

Ohio families and children also directly and indirectly benefit from Medicaid expansion. An estimated 176,000 currently uninsured Ohio parents will be covered by Medicaid expansion. *See Coverage Saves Jobs* (Appendix at 103). By insuring that a significant number of additional parents become Medicaid eligible, not only will more adults get the affordable and effective treatment that they need, but more children will as well. *See id.* Insuring parents increases the likelihood that all members of the family, particularly children, will be insured and thus receive regular and quality medical care. *See id.* To this end, an Institute of Medicine study specifically concluded that insuring parents plays a pivotal role in ensuring children with mental illness and addiction issues receive consistent and successful care. *See America's Uninsured Crisis, Consequences for Health and Health Care* (Appendix at 123).

Moreover, if parents are uninsured, their children are three times more likely to also be uninsured, even if the children would otherwise qualify for Medicaid or similar state or federal programs. *See Coverage Saves Jobs* (Appendix at 103); *America's Uninsured Crisis, Consequences for Health and Health Care* (Appendix at 117-119). As such, expanding Medicaid coverage to parents directly increases the likelihood that eligible children will also be enrolled, and thus begin receiving previously unavailable or unaffordable care. And, the Institute of Medicine study reported that the short and long-term financial stability of a family is placed at risk even if only one person in the family is uninsured, as that one person remains at risk for

incurring unexpected health care costs. *See* America's Uninsured Crisis, Consequences for Health and Health Care (Appendix at 129). Medicaid expansion reduces such risks and increases the likelihood that children otherwise get quality and consistent medical care.

In addition, absent Medicaid expansion, most young adults who were Medicaid eligible as children become ineligible at age nineteen (twenty-one for foster children). *See* Ohio Medicaid Expansion Study (Appendix at 8). Expanded Medicaid will provide for continuity of care for these young adults, many of whom have mental illness and addiction disorders that will worsen absent access to the continued regular treatments and prescription drugs to which they became accustomed to as children covered by Medicaid. The benefits to Ohio children and families from Medicaid expansion are obvious and of critical importance to the overall growth and success of the State of Ohio and the health of its citizens.

c. Impact On Ohio Veterans.

Currently only 37% of veterans in the United States receive healthcare coverage through the Veteran's Administration. *See* Dr. Kenneth W. Kizer, American Medical Association, Veterans and the Affordable Care Act (February 2012) (Appendix at 165-167). In Ohio alone, almost 90,000 veterans and their family members go without health insurance. *See* Northeast Ohio Medicaid Expansion Coalition, Medicaid Expansion: Reduce Uninsured and Provide Coverage to Ohio Veterans, (Appendix at 168) (*available at* <http://www.mtsinaifoundation.org/pdf/Medicaid%20Expansion%20Ohio%20Veterans.pdf>). A recent analysis by the Robert Wood Johnson Foundation and the Urban Institute found that veterans without health insurance coverage regularly have medical conditions that go untreated, some of which are severe. *See* Robert Wood Johnson Foundation and Urban Institute, Uninsured

Veterans and Family Members: State and National Estimates of Expanded Medicaid Eligibility Under the ACA (March 2013) (Appendix at 174).

One in three veterans surveyed reported at least one chronic health condition and reported that they had delayed needed healthcare because of cost concerns. *See Coverage Saves Jobs* (Appendix at 103). In recent testimony before the Controlling Board, Ohio National Guard Adjutant General Deborah Ashenhurst testified that many of her National Guard members regularly worry about access to affordable healthcare coverage, and that such concerns detrimentally affect troop readiness. *See Excerpts of Testimony of Adjutant General Debbie Aschenhurst before the State of Ohio Controlling Board (October 21, 2013)* (Appendix at 178-180).

Under Medicaid expansion, 26,000 currently uninsured veterans and an additional 12,000 spouses and family members would qualify for Medicaid eligibility. *See Medicaid Expansion: Reduce Uninsured and Provide Coverage to Ohio Veterans* (Appendix at 168). Medicaid expansion will thus provide material improvements in the health and quality of life of nearly 40,000 veterans and their families, all of whom have proudly served on behalf of their fellow Ohioans.

d. Impact On Persons Battling Mental Health And Addiction Issues.

Medicaid expansion also exponentially increases the number of adults who will now be able to afford the treatments and prescription drugs necessary to help them cope with and control a variety of debilitating mental health disorders, which otherwise cripple their ability to lead healthy, productive and independent lives. The same is true for those suffering from drug and alcohol dependencies and addictions who, absent obtaining Medicaid coverage, will continue to go through life without the care they need. For many of these adults, young and old, their

inability to afford proper treatment and monitoring causes additional harm to their minor children, parents and other family members and close friends.

Medicaid expansion is not just another government program to the individuals in this group. To them, Medicaid expansion means access to specialists, therapists, physicians, treatments and medicines which can and will forever change their lives for the better. The Amicus Brief of The Ohio Provider Resource Association, The Ohio Council of Behavioral Health and Family Services Providers, The National Alliance on Mental Health, Advocates for Ohio's Future and The Coalition for Healthy Communities discusses in greater detail the benefits of Medicaid expansion on those currently suffering from mental health and addiction disorders and who cannot, absent Medicaid expansion, afford the care they really require.

8. Medicaid Expansion Combats Crime

Ohio law enforcement officers have spoken publicly regarding the impact Medicaid expansion will have on reducing crime, particularly crimes committed by young adults suffering from drug and alcohol addiction and/or untreated mental illness. *See*, The Daily Record, Wooster, Ohio, "Sheriff, mental health board support Medicaid expansion" (January 20, 2013) (Appendix at 181). As previously discussed, the expansion of Medicaid to cover poor young adults will ensure these individuals continue to receive the treatments and prescriptions they received as children covered by Medicaid. In addition, the expansion of Medicaid to cover inpatient hospital services for prison populations will help ensure inmates receive mental illness and addiction services, thus lowering recidivism rates. *See* The Cleveland Plain Dealer, "Could Medicaid expansion decrease drug court costs, save local taxpayer dollars? Cleveland judge says yes" (May 20, 2013) (Appendix at 182-185).

Medicaid expansion ensures more high risk young adults and prisoners receive the treatments and prescription drugs they need, leading to safer communities, healthier and more positive outcomes for high-risk young adults, and fewer incarcerations and repeat offenders. Medicaid expansion thus plays a pivotal role in improving all aspects of Ohio's criminal justice system.

IV. CONCLUSION

For the reasons set forth above, the Court should find that the Controlling Board acted properly and well within its statutory and constitutional authority in approving the Department of Medicaid's appropriation request to fund the Medicaid expansion from which every Ohioan benefits. The amici therefore respectfully urge the Court to deny the Relators' requests for a writ of mandamus.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Amicus Curiae Brief of The Ohio National Guard Association, Sheriff Gene A. Kelly, Clark County Ohio Sheriff, The Ohio Association of Community Health Centers, The Ohio Manufacturers Association, The Ohio Right to Life Society, The Columbus Chamber of Commerce, Philanthropy Ohio, The Dayton Chamber of Commerce, The Cincinnati USA Regional Chamber of Commerce and The Ohio Association of Health Plans In Support Of Respondents The State of Ohio Controlling Board and the Ohio Department of Medicaid has been served upon the following via electronic mail this 25th day of November, 2013:

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APPENDIX

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(March 2013)Appendix pp. 1-24

Brian Haile, The Supreme Court’s ACA Decision and
its Hidden Surprise for Employers, Jackson Hewitt Tax Services, Inc.
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Testimony of Sheriff Michael Heldman before the
House Finance Committee of the Ohio General Assembly
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Health Policy Institute of Ohio Report, Ohio Medicaid Basics
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Brian Haile, The Supreme Court’s ACA Decision and its
Hidden Surprise for Employers, Jackson Hewitt Tax Services, Inc.
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Greg Moody, Health Transformation Budget Priorities, testimony
before the House Finance Committee of the Ohio General Assembly
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Governor’s Office of Health Transformation Policy Brief,
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American Academy of Actuaries,
Implications of Medicaid Expansion Decision on Private Coverage
(September 2012).....Appendix pp. 106-109

Moody’s Investors Service, Medicaid and Medicare DSH
payment reductions could challenge states and hospitals
(March 14, 2013)Appendix pp. 110-112

Excerpts from Institute of Medicine, America’s Uninsured Crisis,
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(2009).....Appendix pp. 113-138

Kaiser Health News, “Rural Poor Likely to Feel the Pinch
of State Decisions Not to Expand Medicaid”
(September 3, 2013).....Appendix pp. 139-140

Bloomberg News, “Hospitals Brace as Republicans Fight Over Medicaid” (September 19, 2013)Appendix pp. 141-144

New England Journal of Medicine, Mortality and Access to Care Among Adults after State Medicaid Expansions (September 13, 2012).....Appendix pp. 145-154

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Northeast Ohio Medicaid Expansion Coalition Report, Medicaid Expansion: Reduce Uninsured and Provide Coverage to Ohio VeteransAppendix p. 168

Robert Wood Johnson Foundation and Urban Institute Report, Uninsured Veterans and Family Members: State and National Estimates of Expanded Medicaid Eligibility Under the ACA (March 2013)Appendix pp. 169-177

Excerpts from Testimony of Adjutant General Debbie Aschenhurst before the State of Ohio Controlling Board (October 21, 2013)Appendix pp. 178-180

The Daily Record, Wooster, Ohio, “Sheriff, mental health board support Medicaid expansion” (January 20, 2013)Appendix p. 181

The Cleveland Plain Dealer, “Could Medicaid expansion decrease drug court costs, save local taxpayer dollars? Cleveland judge says yes” (May 20, 2013)Appendix pp. 182-185

Expanding Medicaid in Ohio

Analysis of likely effects

Introduction

The Ohio Medicaid Expansion Study ("study") was conducted to inform Ohio's leaders who must decide whether to expand Medicaid eligibility to Ohio residents with incomes up to 138 percent of the Federal Poverty Level (FPL). We use two different approaches to estimate the health coverage, fiscal and economic effects of Medicaid expansion, but both approaches yield the same conclusions. Medicaid expansion would:

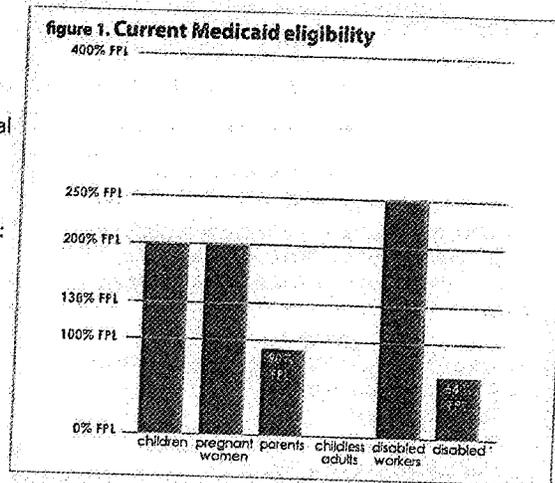
- Increase Medicaid enrollment and, with it, state Medicaid costs
- Create net state budget gains for the next three and a half biennia by generating state budget savings and state revenue that significantly exceed the state's cost of increased enrollment
- Cause state fiscal costs and gains that roughly balance out in fiscal year 2020 and thereafter (although the state is likely to continue receiving small net fiscal benefits from expansion)
- Provide health coverage to hundreds of thousands of Ohio residents who would otherwise be uninsured
- Strengthen Ohio's economy by bringing in federal resources that have already been set aside for Medicaid expansion, creating tens of thousands of jobs within the state's borders
- Reduce health care costs for Ohio's employers and consumers
- Yield significant fiscal gains to Ohio's counties

Background

Medicaid is a state-federal program that provides health coverage to people who meet certain criteria (see figure 1). The financing of the program is shared between the state and federal government through a federal match rate known as FMAP (Federal Medical Assistance Percentage). For Ohio, the current FMAP is generally 63 percent; the state pays the remaining 37 percent of Medicaid costs. The FMAP is higher for certain beneficiary groups, such as children covered under the federal Children's Health Insurance Program (CHIP).

As originally enacted in March 2010, the Patient Protection and Affordable Care Act (ACA) required states to expand Medicaid coverage to people with incomes up to 138 percent of FPL (see chart on page 2). According to this federal law, the federal government will pay 100 percent of the cost for people who are newly eligible for Medicaid from 2014 to 2016, gradually decreasing to

figure 1. Current Medicaid eligibility



90 percent in 2020 and beyond. In June 2012, the U.S. Supreme Court effectively made expansion of Medicaid under the ACA optional, rather than required.

The ACA also provides tax credits and cost-sharing subsidies for people with incomes between 100 percent and 400 percent of FPL who are ineligible for Medicaid to purchase health insurance coverage through health insurance exchanges. Such assistance is limited to residents who lack access to employer-sponsored insurance (ESI) that the ACA classifies as affordable.¹ If Ohio moves forward with Medicaid expansion, most Ohioans with incomes up to 400 percent FPL will have access to subsidized health coverage beginning in 2014. If Ohio does not move forward with Medicaid expansion, thousands of Ohioans below 100 percent FPL will have no subsidized coverage assistance. Citizens and lawfully present immigrants² left without coverage include:

- adults without dependent children and incomes between 0 and 100 percent FPL; and
- parents with incomes between 90 and 100 percent FPL. (see chart on page 2)

The Health Foundation of Greater Cincinnati, the Mt. Sinai Health Care Foundation and the George Gund Foundation sponsored this study to provide Ohio's policymakers with neutral and independent analysis on a key policy decision facing the state — namely, whether to expand Medicaid eligibility. The study was conducted

Ohio Medicaid Expansion Study

	64%	90%	100%	138%	200%	250%	400%
1	\$7,354	\$10,341	\$11,490	\$15,856	\$22,980	\$28,725	\$45,960
2	\$9,926	\$13,959	\$15,510	\$21,404	\$31,020	\$38,775	\$62,040
3	\$12,499	\$17,577	\$19,530	\$26,951	\$39,060	\$48,825	\$78,120
4	\$15,072	\$21,195	\$23,550	\$32,499	\$47,100	\$58,875	\$94,200

Note: Annual guidelines for all states except Alaska, Hawaii and DC. For each additional person, add \$4,020

Source: Federal Register, January 24, 2013

through a partnership of the Health Policy Institute of Ohio (HPIO), The Ohio State University (OSU), the Urban Institute, and Regional Economic Modeling, Inc. (REMI).

The study's primary purpose is to analyze the impact of Medicaid expansion on:

- The state budget
- Ohio economic growth and jobs
- The number of uninsured
- Health coverage, jobs, economic growth, and revenue for regions within the state and some individual counties

The study partners agreed to conduct their analysis based on current federal and state law.

Preliminary findings were released on January 15, 2013 and updated on January 18, 2013. The findings were released with the following caveats:

- Projections inherently involve uncertainty
- Estimates were preliminary and subject to change
- Future analyses would include additional estimates developed using other analytical methods
- While specific preliminary numbers could change, the basic policy implications would likely stay the same

This brief includes refined and additional estimates of costs, savings and revenues associated with a Medicaid expansion. The following additional analyses are reflected in the results presented in this brief:

- Original projections were based in significant part on the Urban Institute's estimated cost and coverage effects of the ACA in Ohio, both with and without a Medicaid expansion. Since then, researchers at OSU have developed an additional set of estimates. As a result, many of the key issues

explored here involve two projections rather than one.

- Analysis regarding the state revenue effects of subsidized individual coverage in the exchange, which will generate insurance tax revenue, has been included. As a result, estimated effects of the ACA without a Medicaid expansion include additional revenue compared to the preliminary estimates presented in January. At the same time, estimated revenue effects of the Medicaid expansion now include less managed care tax revenue. Our preliminary revenue estimates were offset with the reduction in insurance taxes that will result if citizens with incomes between 100 and 138 percent FPL receive coverage through Medicaid rather than through the exchange.
- Since the release of the January preliminary report, estimates of state savings involving retroactive Medicaid payments and payments covering the period between application and final eligibility determination were developed. These estimates generated additional state budget savings in our analysis of the effects of Medicaid expansion as well as estimates for the ACA's non-expansion provisions.
- On February 13, the State of Ohio released Mercer's analysis of ACA cost effects, which estimated the impact of the ACA's insurer fee on Ohio's Medicaid managed care costs. We incorporated Mercer's analysis of the fee as a percentage of total managed care costs (minus "ripple" effects on sales and insurance taxes), which increased our estimated cost of the ACA's provisions not including Medicaid expansion and slightly increased our estimated Medicaid expansion costs.

Results from regional and some county level analysis will be available in late February or early March 2013.

Ohio Medicaid Expansion Study

Study Questions and Methods

The key questions addressed in the study are:

1. Does a Medicaid expansion generate new state Medicaid costs?
2. Does a Medicaid expansion allow state budget savings?
3. How does a Medicaid expansion affect state revenue?
4. What is a Medicaid expansion's net impact on the state budget?
5. How else does a Medicaid expansion affect Ohioans?
6. What impacts will the state experience from the ACA even if Medicaid is not expanded?

One of the study objectives was to use qualitatively different methods of estimating Medicaid cost and coverage effects — microsimulation models and actuarial-type models — to develop a range of possible outcomes. We found that these different analytic approaches produced similar, though not identical, results.

Three separate models were used to address these questions:

The Urban Institute's Health Insurance Policy Simulation Model (HIPSM)

- HIPSM is a "microsimulation model," like the models used by the Congressional Budget Office, the U.S. Treasury Department, and the U.S. Office of Management and Budget.
- HIPSM uses Census Bureau and other government data to develop a detailed picture of Ohio residents and businesses. In this case, HIPSM's picture of Ohio residents was modified to reflect recent cost and enrollment data from the state's Medicaid program.
- HIPSM estimates how Ohio's residents and employers would react to various policy changes, including the ACA, with and without a Medicaid expansion. These estimates are based on the health economics literature and empirical observations.
- HIPSM is being used to estimate the ACA's cost and enrollment effects by the federal government, a number of states, the Robert Wood Johnson Foundation, the Kaiser Commission on Medicaid and the Uninsured, and the Commonwealth Fund.
- HIPSM's methods are all a matter of public record. See <http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf>.
- Urban Institute researchers used HIPSM to estimate the effects of ACA implementation in Ohio, both with and without a Medicaid expansion.

Regional Economic Models, Inc. (REMI)'s Tax-PI Model

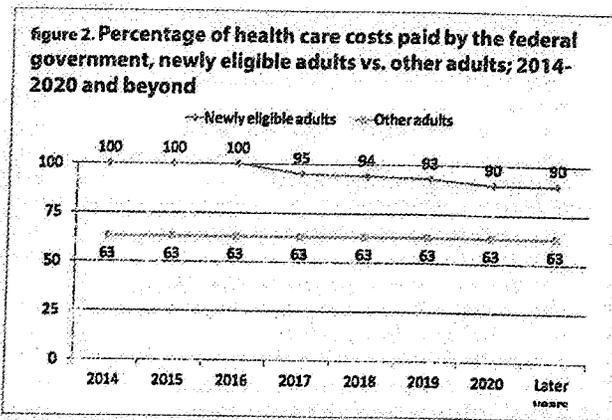
- REMI was founded in 1980, based on the idea that government decision-makers should test the economic effects of policies before implementation. REMI models are used in nearly each U.S. state at all levels of government.
- The Tax-PI model allows users to simulate not only the statewide impact of policy on such variables as jobs, income, gross domestic product, and demographics, but also state revenue and expenditures.
- The REMI model is a structural macro-economic simulation model that integrates input-output, computable general equilibrium, econometric, and new economic geography theories. The model is dynamic and generates year-by-year estimates.
- The model has been used to evaluate the detailed effects of Medicaid expansion in other states and broadly across all 50 states.
- The underlying methods and system of equations have all been peer reviewed and are available at <http://www.remi.com/resources/documentation>.

The Ohio State University Impact of Medicaid Expansion on Ohio model

- The OSU model applies an actuarial approach, generally like that being used by Ohio actuaries who are projecting the ACA's Medicaid cost effects. The OSU model uses data sources and assumptions similar to those in the state's published sources.
- The model uses 2012 Ohio Medicaid Assessment Survey data to estimate the counts and current health coverage status of (a) residents who currently qualify for Medicaid but are not enrolled and (b) residents who will newly qualify for Medicaid if the state implements an expansion.
- The model uses the state's January 2013 to June 2013 Medicaid managed care rates to calculate expected per member per month (PMPM) costs for children, adults, and seniors.
- The model uses the projected annual cost growth and population growth rates currently being used by Ohio Medicaid's actuary to trend PMPM costs and population counts forward (4.6 percent for cost and 1 percent for population growth).
- The model uses the participation rates for each population subgroup that Milliman used in its 2011 Medicaid expansion report for Ohio Medicaid. Milliman assumed that enrollment would gradually rise during 2014 through 2016, reaching final levels by 2017.

Ohio Medicaid Expansion Study

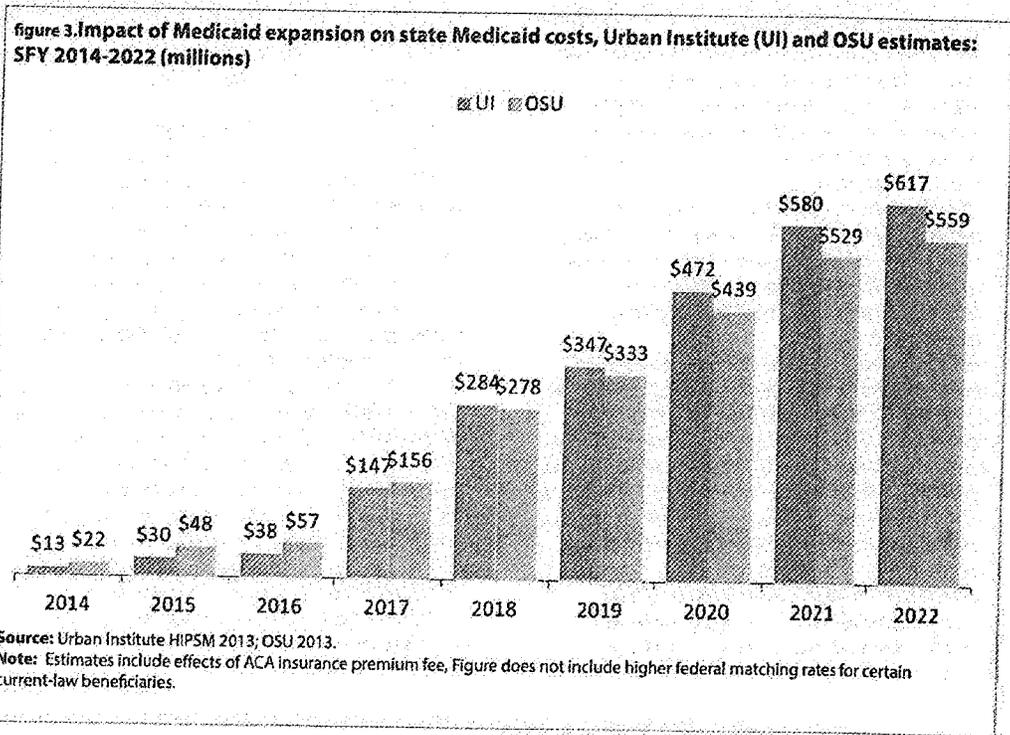
- OSU researchers used the model to develop estimates under two scenarios, each with and without inclusion of seniors:
 - A scenario in which Ohio did not expand Medicaid but the ACA's other provisions resulted in increased participation by currently eligible, but not enrolled individuals.
 - A scenario in which Ohio did expand Medicaid, which resulted in both (a) participation by people newly eligible under expansion and (b) participation by some currently eligible, but not enrolled individuals in addition to the increased participation that would result from implementing the ACA without a Medicaid expansion.
- The model is set up as a systems dynamics model that allows for easy changes of input assumptions to examine how those changes alter the projections of spending and number of people covered.



Question 1: Does a Medicaid expansion generate new state Medicaid costs?

New service costs due to increased enrollment

The Medicaid expansion will generate new state service costs, in addition to Medicaid costs that will be incurred under the ACA without a Medicaid expansion. In part, these new costs are due to the state-share obligation to pay for the newly eligible, 19-64 year



Ohio Medicaid Expansion Study

old Ohioans who would be eligible for Medicaid only under an expansion. The federal government will pay 100 percent of these costs from calendar years (CY) 2014 through 2016. After 2016 the state will begin paying some of these costs, with a share that gradually increases to 10 percent by CY 2020, remaining at that percentage thereafter. (see figure 2)

A second new cost is associated with people who are currently eligible for Medicaid, but not enrolled. According to both the Urban Institute's microsimulation model and the assumptions underlying OSU's actuarial-type model, most of the currently eligible, but not enrolled consumers who join Medicaid after 2014 will do so even if there is no expansion. Such increased enrollment will result from the ACA's individual coverage requirement, new subsidies in the HIX, the ACA's new and streamlined systems of Medicaid enrollment, and increased awareness of the availability of health coverage. However, some additional enrollment of people who are currently eligible but not yet enrolled would result from the expansion. We find that roughly 17.5 percent of the total currently eligible but unenrolled people who sign-up for Medicaid under the ACA with an expansion do so only because of the expansion; the remainder join the program with or without a Medicaid eligibility expansion. Ohio will pay its usual state match rate (currently 37 percent) for such people.

Therefore, as Figure 3 shows, the state cost of Medicaid expansion begins at \$13 to \$22 million in state fiscal year (SFY or FY) 2014 and increases to between \$559 to \$617 million in SFY 2022. SFY 2021 is the first year when the entire state match for newly eligible adults is at the "steady state" of 10 percent. The costs continue to rise thereafter due to population growth and the general trend of increasing health care costs, assumed to be 1 percent and 4.6 percent per year, respectively, under the OSU analysis.

Administrative costs

Our analysis did not have sufficient data to develop a precise estimate of the effect of Medicaid expansion on state administrative costs. Expansion would both add administrative costs and yield administrative savings; it is not clear whether, on balance, the state fiscal effects are positive or negative.

Many of the ACA's administrative cost effects will occur even if Ohio does not expand Medicaid eligibility. For example:

- Other ACA provisions are likely to increase the number of Medicaid applications, with a corresponding rise in administrative expenses to

process those applications.

- Additional administrative costs include major changes to Medicaid eligibility systems, including the implementation of a new Modified Adjusted Gross Income (MAGI) standard, an expanded use of data matching in both establishing and renewing eligibility, and development of systems for coordinating applications, eligibility determination, and redeterminations with the federally facilitated health insurance exchange that will serve Ohio residents. The federal government pays 90 percent of the costs of necessary information technology (IT) development, but the remaining 10 percent must be paid by the state. This major transition also absorbs considerable staff time from state Medicaid officials.
- The new Medicaid eligibility and enrollment system likely will create significant efficiencies, in terms of being less paper intensive, less manual, and more automated. Also, automated eligibility costs will receive a 75 percent federal match, rather than the standard 50 percent match that applies to most administrative costs.
- Other aspects of the ACA require state administrative effort, including the requirement to develop new payment mechanisms to deliver the ACA's federally-funded increase in primary care payments for CY 2013 and 2014.

In addition to the administrative costs the ACA will generate, with or without a Medicaid expansion, the following will generate new administrative costs only if Medicaid is expanded:

- The state would need to process additional applications for people who seek coverage only under an expansion.
- More redeterminations of eligibility would be needed, due to a larger population of Medicaid enrollees.
- The amount of total fee-for-service payments would increase, since new Medicaid participants receive fee-for-service care during the brief time period before selecting a Medicaid managed care organization (MCO). Therefore, the administrative costs of claims processing would rise.
- Increased enrollment in Medicaid managed care plans may raise state administrative costs slightly. For example, the state would need to help more consumers select a plan. However, increased use of Medicaid managed care mainly involves larger payments from the state to insurers, which does not affect administrative costs. The state's purchase on behalf of more covered lives would give the Medicaid program additional negotiating leverage, which might lower the state's overall costs.

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Any new costs in the above areas will be offset, to some degree, by the following administrative savings, which involve a 50 percent state share of cost:

- With a Medicaid expansion, many who would have qualified through spend-down — that is, by incurring sufficient medical expenses to qualify as “medically needy” — will instead be enrolled simply on the basis of income. That would avoid the sometimes cumbersome and costly administrative process of verifying that beneficiaries have incurred expenses that meet monthly applicable spend-down requirements, which vary based on each individual’s precise income.
- With a Medicaid expansion, many who would have qualified based on disability will instead be eligible based simply on income below 138 percent FPL. This will reduce the number of necessary disability determinations, which can be quite costly.
- A Medicaid expansion should reduce the number of retroactive and backdated eligibility determinations. With continuous coverage between 0 and 138 percent FPL, fewer beneficiaries will have their coverage stop and start based on income fluctuations. Since more will be continuously enrolled, fewer will need to have eligibility established to cover services provided before the date of a new eligibility determination. And fewer will churn on and off the program, forcing redundant eligibility determinations.
- An expansion would reduce the number of requests for fair hearing review of coverage denials. Without an expansion, many people who apply at the exchange will be routed to Medicaid based on income too low for exchange subsidies. Medicaid will deny coverage to those who are not eligible. These applicants have an absolute right, under federal law, to request fair hearings, which the state must provide and fund. By contrast, a Medicaid expansion would cover all applicants with incomes too low for exchange subsidies, resulting in many fewer denials and fair hearings.
- A Medicaid expansion, with a corresponding implementation of the state’s proposed eligibility simplification, would reduce the overall complexity of administering a program that, today, maintains over 150 different eligibility groups.

Question 2: Does a Medicaid expansion allow state budget savings?

Medicaid expansion generates new state costs, but that does not mean that Medicaid expansion creates a budget problem for Ohio’s state government. Along with the new state Medicaid costs come two possible sources of offsetting budgetary gains:

1. State budget savings that result from or are allowed by Medicaid expansion; and
2. State revenue created by Medicaid expansion.

A Medicaid expansion generates state budget savings in two ways:

1. It shifts existing Medicaid spending from the current state match rate to the enhanced expansion match rate, which begins with full federal funding; and
2. It replaces non-Medicaid spending of state general revenue fund dollars on health care for the poor and near-poor uninsured with federal Medicaid dollars as those people gain Medicaid eligibility.

This analysis quantifies four primary sources of state savings opportunities and several minor savings possibilities. Three of the primary opportunities relate to shifts in current Medicaid spending involving —

- Adults with spend-down coverage;
- Breast and cervical cancer program; and
- Retroactive and backdated fee-for-service spending.

The remaining savings opportunity, inpatient medical costs for state prisoners, shifts non-Medicaid spending that is 100 percent state-financed to Medicaid coverage for newly eligible adults, for whom the federal government pays between 90 and 100 percent of all costs, depending on the year.

Adults with spend-down coverage

Under Ohio’s coverage of the “aged, blind, and disabled” (ABD), non-elderly residents with disabilities qualify for Medicaid so long as their incomes do not exceed 64 percent FPL. Residents with incomes above that threshold on the first day of the month can, under Ohio Medicaid’s spend-down program, become Medicaid eligible later that month once they incur sufficient medical expenses. Such spend-down adults who do not receive Medicare and have incomes at or below 138 percent of FPL would no longer incur

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table 1. Net savings on spend-down adults (millions)

Fiscal year	Net savings on spend-down adults
2014*	\$36
2015	\$74
2016	\$78
2017	\$80
2018	\$82
2019	\$86
2020	\$87
2021	\$91
2022	\$96
Total	\$709

Source: OSU 2013. Note: columns may not total due to rounding.

the medical bills needed for spend-down eligibility. Instead, they would immediately qualify as "newly eligible adults," for whom the state would receive enhanced federal matching funds.

Ohio Medicaid's eligibility simplification draft waiver application (<http://1.usa.gov/Zsa6fl>) estimated the costs associated with the spend-down population between CY 2014 and CY 2018. According to this document, there would be 8,505 individuals with incomes between 70 percent and 133 percent of poverty in CY 2014 with total spending of \$194 million dollars and 8,851 individuals with total spending of \$241 million in CY 2018. In our analysis we trended these costs forward using the same growth rate as in Ohio Medicaid's numbers through CY 2022.

When someone moves from eligibility as an adult with spend-down to a newly eligible adult, total Medicaid spending on that person increases, as Medicaid covers the charges previously incurred by the individual to meet spend-down obligations. However, the percentage of Medicaid costs paid by the state falls dramatically. Instead of 37 percent, the state's share of these costs is zero during CY 2014-2016, then gradually rises to 10 percent in CY 2020 and thereafter.

Our analysis trended forward Ohio Medicaid's estimates of both cost effects — namely, total Medicaid costs for these adults and the share paid by the state. We found that Medicaid expansion will generate savings, reflecting the difference between what the state currently spends for these individuals at the regular match rate and what Ohio would spend under the enhanced expansion match rate.

Table 1 shows the net savings, after accounting for the increased spending and the differences in match rates. According to our analysis, the savings will be \$36 million in SFY 2014 and grow to \$96 million in 2022, with total savings of \$709 million over the period of SFY 2014 to SFY 2022.

Breast and cervical cancer program (BCCP)

The breast and cervical cancer program (BCCP) is an optional Medicaid coverage population. To be eligible for BCCP a woman must be uninsured and diagnosed with breast and cervical cancer at a breast and cervical cancer testing site approved by the Centers for Disease Control and Prevention (CDC). The woman must also have an income that is at or below 250 percent of poverty.

With a Medicaid expansion, women not already enrolled would no longer need the BCCP program. Almost all women who otherwise would have qualified for BCCP will instead either be newly eligible adults in Medicaid or qualify for subsidies offered through the health insurance exchange. They will be ineligible for the BCCP program both because they are insured and because, in many cases, they will not receive a diagnosis of cancer from a CDC-approved site.

According to Ohio Medicaid's eligibility simplification waiver application, 610 women are expected to be covered under the BCCP program in CY 2014 at a total cost of \$19 million, rising to 634 women and a total cost of \$24 million in CY 2018. This total spending equals \$7 million state share in 2014 and almost \$9 million in 2018, since the state receives enhanced, CHIP-level federal funding for this eligibility group. Our analysis trended these costs forward at the rate of growth used in Ohio Medicaid's own estimates.

Table 2 shows the costs savings to Ohio Medicaid under expansion, assuming that women who otherwise would have enrolled in the BCCP program instead sign up for Medicaid as newly eligible adults. The savings would start at \$2 million in SFY 2014 and, as current enrollees gradually leave the program, grow to \$7 million in SFY 2022, for a total of \$48 million in savings over the period SFY 2014 to SFY 2022. The savings could be even higher if a portion of these costs went entirely away as the women got their coverage through the health insurance exchange rather than Medicaid (although a portion of those savings would be experienced even without a Medicaid expansion).

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table 2. BCCP savings (millions)

Fiscal Year	BCCP Savings
2014	\$2
2015	\$5
2016	\$5
2017	\$5
2018	\$6
2019	\$6
2020	\$6
2021	\$6
2022	\$7
Total	\$48

Source: OSU 2013. **Note:** The current BCCP program has federal matching rates between standard and ACA levels. Estimates assume that all new BCCP enrollees receive Medicaid as newly eligible adults. If some enroll instead in the exchange, state savings would increase, because the state would not spend anything for their care. However the latter savings would occur with or without expansion.

Retroactive eligibility and backdated eligibility

One attribute of the Medicaid program is that it serves as a kind of high risk pool. Individuals who would not qualify for Medicaid on one day might well qualify on another day if their health status changes significantly enough. Often this change first shows up through a health event that requires expensive medical attention, which may require disposing of liquid

assets. Such impoverishment can qualify patients for Medicaid. Also, sometimes a previously eligible person does not undertake the effort required for enrollment until experiencing a medical problem.

For those people whose application is approved, Medicaid will pay costs incurred during the three months before the application date. Such coverage is known as retroactive eligibility. In addition, when there is a delay between the date of application and the ultimate determination of eligibility, Medicaid pays the costs incurred between those two dates. Such coverage is often called "backdated eligibility." Both retroactive and backdated coverage involve fee-for-service claims. People receiving backdated or retroactive coverage enter into managed care plans after they have been found eligible for Medicaid and selected a managed care plan.

Under current Medicaid these individuals either apply for ABD coverage or for Covered Families and Children (CFC) eligibility. The processing time for ABD applications currently averages 3 months, because of the complexities related to completing the disability determination process. The processing time for CFC is typically under one month.

With Medicaid expansion, all individuals aged 19 to 64 with incomes below 138 percent of poverty will qualify, with eligibility based entirely on income, without regard to assets. They will not have to wait for a major health event before obtaining coverage.

table 3. Impact of Medicaid expansion on state costs for retroactive and backdated eligibility: FY 2014-2022 (millions)

Fiscal year	Net savings on retroactive eligibility spending	Net savings on backdated eligibility spending	Total savings on backdated and retroactive eligibility
2014	\$0	\$0	\$0
2015	\$0	\$0	\$0
2016	\$26	\$44	\$70
2017	\$27	\$47	\$74
2018	\$28	\$48	\$76
2019	\$29	\$50	\$79
2020	\$30	\$52	\$82
2021	\$31	\$54	\$85
2022	\$33	\$57	\$90
Total	\$204	\$352	\$556

*Assumes savings begin in SFY 16 after full take up has occurred and change in spending is documented and reflected in budgeting process.

Source: OSU 2013. For assumptions, see text.

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Coverage will become more continuous for a second reason — namely, with higher income eligibility standards, and the elimination of all categorical restrictions for non-elderly adults with incomes below 138 percent FPL, fewer changes in household circumstances will cause eligibility to end or begin. When applications are required for people with incomes below that threshold, they will be processed much more quickly, because a disability determination will not be necessary. Moreover, as the uninsured gain coverage, the number of months of retroactive and backdated eligibility experience will decline, which will reduce spending on retroactive and backdated eligibility.

These changes should result in two offsets. First, we subtract the estimated reduction in retroactive benefits from the increased Medicaid costs that would result from expansion. Otherwise, those costs will be counted twice: once as “retroactive costs” that will be incurred through the continuation of the present Medicaid program; and a second time as managed care spending on the newly enrolled. In truth, the latter spending will replace current retroactive benefits.

Second, the backdated eligibility costs for people who, today, eventually qualify based on disability should diminish substantially. Such people with incomes at or below 138 percent FPL will qualify quickly based on income, with no need to wait for a disability determination.

As a result, the state should receive enhanced federal match for their care, rather than the standard federal match rate, except for people who seek and qualify for Medicare or disability-based cash assistance. Further, we assume that the state provides newly eligible adults with the same benefits other adults receive. This will ensure that people who qualify as newly eligible adults have no reason to request a disability determination, since such a determination would not provide them with additional coverage.

We limit our estimated savings in this area to the ABD population, since most of the increased enrollment within the CFC group will take place under the ACA without expansion. To estimate retroactive and backdated costs for non-Medicare enrollees within the ABD population, we take the state's current costs and trend them forward, using the state's estimated cost increase of 4.6 percent per year. We begin with a reduction in such costs based on the proportionate decline among uninsured residents with incomes at or below 138 percent FPL, which likely understates

the percentage of people with backdated eligibility who would seek to qualify as newly eligible adults. We calculate the resulting savings assuming that only half of these costs would be eliminated by expansion, recognizing that some of these individuals may have incomes above 138 percent FPL and others may apply for and receive cash assistance based on disability, thus falling outside the newly eligible adult category.

We also assume that these will start to accrue in SFY 2016 given the potential costs of pent-up demand during the take up period and the lag in use of spending data to set new rates for managed care. Using these conservative assumptions, we estimate savings of:

- \$26 million in SFY 2016 to \$33 million in SFY 2022, for a total of \$204 million in savings from SFY 2014 to SFY 2022 for retroactive eligibility;
- \$44 million in SFY 2016 to \$57 million in SFY 2022, for a total savings of \$352 million in savings for backdated eligibility from SFY 2014 to SFY 2022.

In-patient medical costs of state prisoners

Under current Medicaid rules, state prisoners can qualify for Medicaid coverage of inpatient and institutional services if they stay outside of the prison setting for at least one night, but only if the prisoners meet all other Medicaid eligibility requirements. Almost all prisoners are ineligible for Medicaid under current law because they are childless adults who fall outside the limited categories of pre-ACA Medicaid eligibility. That will change under Medicaid expansion because eligibility will shift from categorical requirements to eligibility based solely on income below 138 percent of poverty.

As a result, Ohio's prison budget should benefit from a Medicaid expansion. According to the Ohio Department of Rehabilitation and Corrections, in 2012 Ohio spent almost \$28 million on prisoners' inpatient costs. Given utilization management strategies used in this system, we assumed a lower cost trend (3 percent) than used in other estimates.³ Based on these cost trends we estimate that Ohio will spend \$30 million in SFY 2014 and \$37 million in SFY 2022.

Table 4 shows the estimated savings from shifting inpatient costs of state prisoners from 100 percent funded by the state prison budget to Medicaid funding for newly eligible adults, with the federal government paying between 90 and 100 percent of these costs, depending on the year. Our analysis estimates that this opportunity will result in \$15 million dollars of savings in SFY 2014 rising to \$34 million in SFY 2022.

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table 4. Savings on inpatient care to prisoners (millions)

Fiscal Year	Savings on inpatient care to prisoners
2014*	\$15
2015	\$31
2016	\$32
2017	\$32
2018	\$32
2019	\$32
2020	\$33
2021	\$33
2022	\$34
Total	\$273

Source: OSU 2013. Note: columns may not total due to rounding.

Mental Health and Substance Abuse Treatment

There are several other potential state savings that are challenging to quantify. Most of these savings relate to state spending to assist people who are currently uninsured. Ohio's health-related state agencies, such as the Ohio Departments of Mental Health, Alcohol and Drug Addiction Services and Health, currently fund some health services for people without insurance. Funding typically is distributed to local governmental entities or local agencies that provide these services. Local governmental entities may also have local funding generated through levies that pay for services for people without insurance. An expansion of Medicaid will reduce the number of uninsured and provide federal funding to replace services that are entirely funded by state and local dollars today. These state and local dollars can then be used to provide services to those who will remain uninsured or provide services that are not a part of a Medicaid benefit package, such as housing or employment supports.

In the case of mental health and alcohol and drug addiction spending, estimating the specific amount of state savings, as opposed to local savings, is not possible with existing reporting methods. For instance, in SFY 2011 local governmental entities known as county behavioral health boards "spent \$98.3 million on treatment services included in the mental health Medicaid package for the uninsured."⁴ Based on the information available to us, we could estimate neither the proportion paid by the state nor the amount spent to serve adults who could qualify

as newly eligible based on income at or below 138 percent of FPL. A similar situation exists for funding of alcohol and drug addiction services.

Looking at the issue from a slightly different perspective, in SFY 2013 approximately \$60 million dollars in state mental health funding (SFY 2013 MH 335-505 allocation) and approximately \$10 million dollars in state alcohol and drug addiction funding (SFY 2013 ADA 401 and 475 allocations) was distributed to local boards. However, with the exception of \$14.6 million that was designated for specific mental health purposes, consistent data are not available showing the precise use of these funds. We could not determine, at this time, the proportion that could be replaced by Medicaid funding for newly eligible adults under an expansion.

Other Medicaid program savings

Within the Medicaid program itself there are several other possible sources of savings that we have not included in our estimates of the fiscal impact of expansion:

- **Family Planning Waiver Program:** Ohioans qualifying for this program would become eligible for coverage through Medicaid expansion or on the health insurance exchange. They should prefer either coverage option as the family planning waiver offers a limited benefit package that only covers family planning services. Their pre-ACA coverage consisted of less than full-scope Medicaid, so they can qualify as newly eligible adults if their income does not exceed 138 percent FPL.
- **Transitional Medical Assistance (TMA):** Individuals covered through TMA have experienced an income increase that makes them no longer financially eligible for Medicaid. Current Medicaid rules allow these individuals to maintain their Medicaid coverage for between six months to a year as an incentive for people to seek higher incomes. If the federal Centers for Medicare and Medicaid Services (CMS) permit Ohio to cover these individuals as newly eligible, benefiting from enhanced match, the state would receive additional Medicaid savings of more than \$100 million a year.
- **Pregnant Women:** Along similar lines, our estimates do not include savings on pregnant women with incomes at or below 138 percent FPL. In theory, such women who would have qualified for Medicaid under the state's pre-ACA rules should be ineligible for enhanced federal funding

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as newly eligible adults. In practice, however, most such women will enroll before they become pregnant. They will receive coverage as newly eligible adults, with enhanced federal funding. CMS has ruled that states do not need to track whether newly eligible adults become pregnant. It is not yet clear whether, as a result, states can simply claim enhanced match for such women among the other newly eligible adults. If they can, Ohio could realize substantial additional savings not shown here.

Question 3: How does a Medicaid expansion affect state revenue?

Along with savings from existing spending, Medicaid spending will increase state revenues in three different ways, including:

- Increased Medicaid managed care tax revenues
- Increased general state revenue dollars
- Increased pharmacy rebate revenues

Medicaid payments to managed care plans are subject to a 1 percent health insuring corporation (HIC) tax and a 5.5 percent sales and usage tax. These payments are also subject to local sales and usage tax, which averages 1.35 percent across all 88 Ohio counties.

This tax applies only on the spending that comes through managed care plans in the form of capitation payments. The tax does not apply to that portion of the capitation payment that reimburses the Medicaid managed care plans for the tax obligation.

In estimating the managed care tax revenue, this analysis estimated the portion of new spending that is expected to go to managed care plans. According to the current Medicaid state budget book, 12 percent of total spending for the CFC population is fee-for-service (FFS) spending and 88 percent is for managed care. Since we expect the expansion population will resemble the CFC population experience much more than the ABD population experience, we projected that 88 percent of total spending would be subject to the managed care tax. Before calculating the tax we then reduced that amount by 7.85 percent to remove the cost of the tax from the amount on which state taxes are levied.

We next calculated the revenues that would be earned under the 1 percent HIC tax, the 5.5 percent state sales and usage tax, and the 1.35 percent local sales and usage tax. In calculating state revenues, we only included the revenues from the 1 percent HIC tax and the 5.5 percent state sales tax. We show the local sales tax revenues in a later section.

In calculating the state revenue, we offset a revenue loss that will result from Medicaid expansion. Such an expansion would reduce the number of people covered in the exchange since it would prevent citizens and qualified immigrants with incomes between 100 and 138 percent of FPL from receiving subsidized coverage in the exchange. The latter coverage generates revenue through either the 1 percent HIC tax or the 1.4 percent insurance premium tax. We therefore subtract this lost revenue from the state's increased receipt of managed care taxes in estimating the net state revenue gains from taxation on insurance premiums. To be conservative in our estimate, we assumed the revenue lost estimate from the higher of the two potentially applicable tax rates.

We do not offset the state's payment, through Medicaid, of part of these managed care tax costs, since those state payments are also included in our estimates of the increased state expenditures that would result from higher enrollment under the Medicaid expansion. To analyze net state budget effects of expansion, managed care costs paid by Medicaid need to be treated in the same way for both the cost analysis and the revenue analysis. We have done this by including these costs in both places, but one could achieve the same result by excluding them from both categories.

Table 5 shows the estimated net state revenues from the Medicaid managed care tax for both the Urban Institute and the OSU model results, which rise from \$33 to \$279 million under the Urban Institute model and from \$46 to \$243 million under the OSU model.

Table 5. Net increase in state managed care tax revenues resulting from Medicaid expansion, under Urban Institute (UI) and OSU estimates: FY 2014-2022 (millions)

Fiscal Year	UI	OSU
2014	\$33	\$46
2015	\$108	\$132
2016	\$155	\$164
2017	\$190	\$183
2018	\$214	\$195
2019	\$230	\$206
2020	\$245	\$218
2021	\$262	\$230
2022	\$279	\$243
Total	\$1,717	\$1,617

Source: Urban Institute HPSM 2013, OSU 2013.
Note: columns may not total due to rounding.

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State general revenue

A Medicaid expansion would cause the state to receive a large increase in federal dollars as shown in Table 6. These dollars vary between the Urban Institute and OSU models:

- Increasing from \$1 billion in SFY 2014 to \$5 billion in SF 2022 under the Urban Institute model; and
- increasing from \$1.3 billion to \$4.4 billion under the OSU model.

These new federal Medicaid funds resulting from expansion would be slightly offset by a loss of federal subsidy dollars that otherwise would have funded exchange coverage for citizens and qualified aliens with incomes between 100 and 138 percent FPL. The net result of these two trends is a substantial infusion of additional federal funds to purchase health care services. The health care providers receiving these dollars in turn would buy other goods and services, much of it from Ohio businesses. The resulting increase in economic activity generates increased state revenue from state sales taxes and individual and corporate income taxes.

To estimate these macroeconomic and revenue effects, our analyses used the Tax-PI model from Regional Economic Models, Inc. (REMI). In the past, REMI's modeling has been used by Ohio policymakers to estimate the effects of the Commercial Activity Tax (CAT) changes. REMI's analysis quantifies the health care dollars that are spent within the state's borders and those that are spent in other states, based on data about prior patterns of health care spending by Ohio residents. Put differently, REMI distinguishes between Ohio residents' increased demand for health care, resulting from Medicaid expansion, and the purchase of health care from Ohio providers. Most such demand, but not all, translates into

table 6. Increase in federal Medicaid funds resulting from Medicaid expansion, under UI and OSU estimates: FY 2014-2022 (millions)

Biscal Year	UI	OSU
2014	\$1,000	\$1,339
2015	\$2,466	\$2,862
2016	\$3,282	\$3,346
2017	\$3,802	\$3,598
2018	\$4,076	\$3,690
2019	\$4,295	\$3,858
2020	\$4,495	\$3,991
2021	\$4,723	\$4,152
2022	\$5,026	\$4,386
Total	\$33,165	\$31,222

Source: Urban Institute HIPS 2013; OSU 2013.

increased sales of health care goods and services. Likewise, REMI estimates the extent to which health care providers purchase other goods and services within the state, based on historical trend data.

The economic impact in terms of employment, earnings, and growth is described later. For purposes of the state budget analysis, REMI's analysis found, using the results of both Urban Institute and OSU estimates, that a Medicaid expansion would increase total state general revenue by between \$816 million (OSU model) and \$857 million (Urban Institute model) from SFY 2014 through SFY 2022 (see Table 7).

table 7. Increased state sales and income tax revenue resulting from Medicaid expansion under UI and OSU cost and coverage estimates and REMI macrosimulation: FY 2014-2022 (millions)

Biscal Year	UI	OSU
2014	\$25	\$35
2015	\$61	\$76
2016	\$82	\$87
2017	\$97	\$94
2018	\$106	\$97
2019	\$113	\$101
2020	\$118	\$104
2021	\$124	\$108
2022	\$132	\$114
Total	\$857	\$816

Source: Urban Institute HIPS 2013; OSU 2013, REMI, 2013.
Note: columns may not total due to rounding.

Prescription drug rebates

Under current Medicaid rules, Ohio receives prescription drug rebates from prescription drug manufacturers for pharmacy spending. According to Ohio Medicaid data, the rebates come to 46.65 percent of prescription drug costs for managed care adults and 21.64 percent for managed care children, and 54.2 percent for fee-for-service adults and 25.14 percent for fee-for-service (FFS) children. There is also a two-quarter lag on collections of the rebates.

To calculate the amount of prescription drug savings, this analysis used the expected percent of expenditures for children and adults to be occurring under managed care and FFS payments, as described above, based on the state's prior Covered Families and Children (CFC) experience. The analysis then created a blended per member-per month (PMPM) rate based on these percentages and multiplied that percentage across the estimated spending for pharmaceuticals in each year.

Ohio shares these rebates with the federal government, based on the percentage of Medicaid pharmaceutical costs paid by the federal government.

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table 8. Increased prescription drug rebates resulting from Medicaid expansion, under UI and OSU estimates: FY 2014-2022 (millions)

Fiscal year	UI	OSU
2014	\$1	\$1
2015	\$8	\$4
2016	\$3	\$5
2017	\$20	\$21
2018	\$25	\$25
2019	\$31	\$31
2020	\$43	\$42
2021	\$45	\$45
2022	\$47	\$47
Total:	\$218	\$221

Source: Urban Institute HIPSM 2013; OSU 2013.

Accordingly, during CY 2014 to 2016, the state receives rebate revenue only for the currently eligible but not enrolled individuals who join Medicaid because of an expansion. In later years, as Ohio begins paying a small proportion of costs for newly eligible adults, it begins receiving increased rebate revenue for the prescription drug coverage furnished to those adults. Table 8 shows the following:

- According to Urban Institute estimates, prescription drug rebates resulting from a

Medicaid expansion start at \$1 million in SFY 2014 and grow to \$47 million in SFY 2022. Total prescription rebate revenue is estimated to be \$218 million between SFY 2014 and SFY 2022.

- According to OSU's estimates, prescription rebate revenue also starts at \$1 million in SFY 2014 and rises to \$47 million in SFY 2022. OSU estimates that prescription drug rebate revenue totals \$221 million between SFY 2014 and SFY 2022.

Question 4. What would be the net effect of Medicaid expansion on the state budget?

Adding the Medicaid expansion to the rest of the ACA would create state costs, allow state savings, and affect state revenue. Putting all these effects together yields a clear picture of expansion's overall impact on the state budget:

- For the next three and a half biennia — that is, through FY 2020 — the expansion would have an unequivocal positive impact on the state budget. Net fiscal gains would range between \$350 million and \$400 million during SFY 2014-2015 to between \$133 and \$142 million in SFY 2020 (Table 9).
- State Fiscal Year 2021 is the first complete fiscal year during which federal funding for newly eligible adults is at the 90 percent level — the

table 9. 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
Total:	\$2,529	\$2,421	\$1,587	\$2,792	\$2,654	\$1,851	\$1,820

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 138 percent 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.

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same level where it will stay thereafter, under current federal law. During both SFY 2021 and 2022, the net fiscal gains remain positive, with both the Urban and OSU models estimating net fiscal savings of \$67 million to \$71 million in both years.

The significance of positive results for FY 2021-22 should not be overstated. The inherent uncertainties of projecting costs and revenues this distance into the future are considerable. That said, what both the Urban Institute and OSU modeling show is that, in the "steady state" that will begin in FY 2021, the state's fiscal gains are roughly comparable to the state's costs of Medicaid expansion, with a reasonable likelihood of ongoing, small net budget gains.

This steady state should not be too surprising in Ohio. As noted above, Ohio's managed care tax brings in revenues that equal 6.5 percent of capitated payments. In effect, the tax raises approximately 60 percent of the state's required 10 percent share of spending for newly eligible adults under the expansion. All the other savings and revenues need cover only the remaining 40 percent of the state's costs.

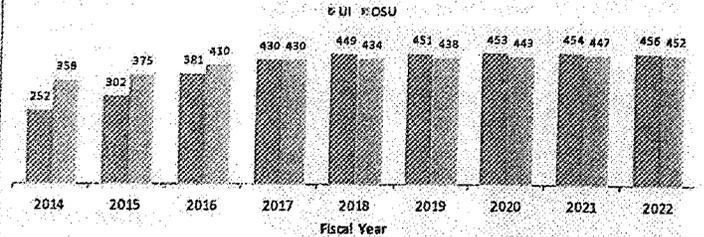
5. How would a Medicaid expansion affect Ohio residents?

Medicaid expansion would affect state residents in many ways that go beyond the state budget.

Fewer uninsured

Many more people would be uninsured without a Medicaid expansion. Adults without dependent children with incomes below 100 percent FPL and parents with incomes between 90 and 100 percent FPL would be ineligible for subsidized health coverage. The vast majority of these adults would be uninsured. Further, without a Medicaid expansion, people with incomes between 100 and 138 percent FPL might qualify for subsidized coverage in health insurance exchanges (HIX), rather than Medicaid. Some who would have enrolled in Medicaid would decline HIX coverage, because of higher premium costs or the risk of owing money to the Internal Revenue Service if annual income turns out to exceed projected levels.

Figure 4. The number of Ohio uninsured who would gain coverage from a Medicaid expansion under Urban Institute and OSU estimates (thousands)



Source: Urban Institute HIPS 2013; OSU 2013. **Note:** FY 2014 results are for January through June 2014. Figure shows the difference between the total number of uninsured, with and without a Medicaid expansion, in each year. It does not show the number of additional uninsured who will gain coverage each year. Figure shows net effects of changes to Medicaid and private coverage. Figure shows the impact of Medicaid expansion. Figure does not include the uninsured who will gain coverage under the ACA's other provisions.

Further, those who are offered employer-sponsored insurance (ESI) where worker-only coverage costs no more than 9.5 percent of household income will be ineligible for HIX subsidies. The net result of these factors is that, by the time it is fully phased in, the Medicaid expansion would cover, by the end of the nine-year period for which we provide estimates, more than 450,000 Ohio residents who otherwise would be uninsured (Figure 4).

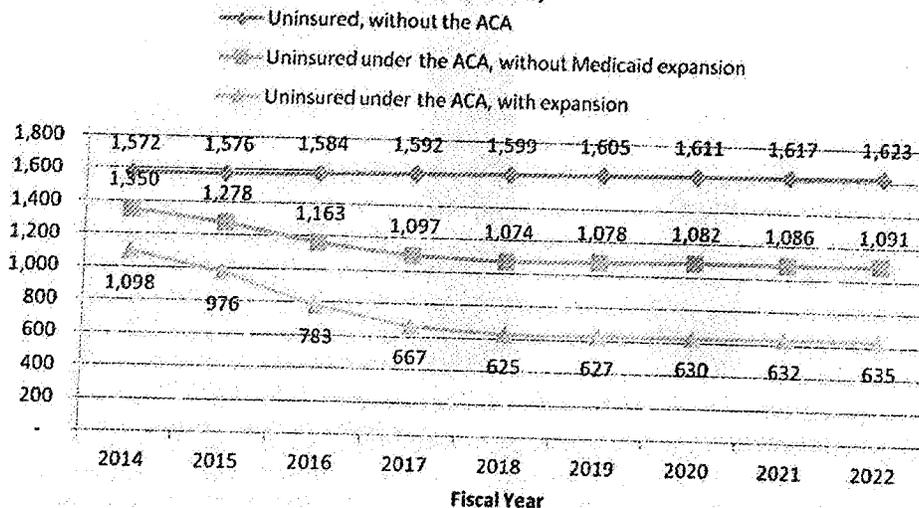
With or without a Medicaid expansion, the ACA will reduce the number of Ohio uninsured. Many will receive subsidized coverage in the HIX. Others who currently qualify for Medicaid but are not enrolled will sign up, for multiple reasons explained above. Still others with incomes too high for any form of help but who have preexisting conditions that prevented them from obtaining individual coverage will be able to purchase insurance due to the ACA's prohibitions of insurance company discrimination against people with health problems. And still others will be motivated to purchase coverage by the ACA's legal requirement for individuals to obtain insurance. The net effect is that, without a Medicaid expansion, the number of uninsured in Ohio will decline by roughly 532,000 as of FY 2022. Adding the Medicaid expansion would cause the number to decline still further, by more than 450,000 people (Figures 5 and 6).

Whether or not the state implements the Medicaid expansion, the state will continue to have thousands of uninsured residents, for many reasons. For example, according to Urban Institute estimates for CY 2022, under the ACA with a Medicaid expansion (Figure 7):

- 44,000 uninsured will be undocumented immigrants who are ineligible for help;
- 291,000 uninsured will qualify for Medicaid or CHIP but not be enrolled;

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figure 5. The number of Ohio uninsured, with and without the ACA, with and without a Medicaid expansion, under Urban Institute estimates (thousands)



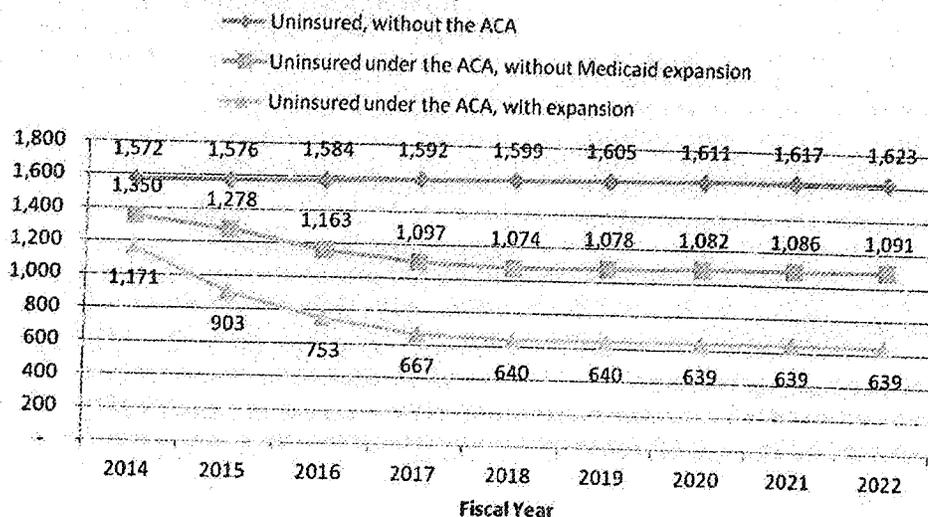
Source: Urban Institute HPSM 2013. FY 2014 results are for January through June 2014.

- 189,000 uninsured will qualify for HIX subsidies but not be enrolled; and
- 112,000 uninsured will be ineligible for any form of assistance and will not buy unsubsidized coverage. They will be ineligible, either because their income exceeds 400 percent FPL or they are income-eligible for exchange subsidies but disqualified by an offer of ESI that the ACA classifies as affordable.

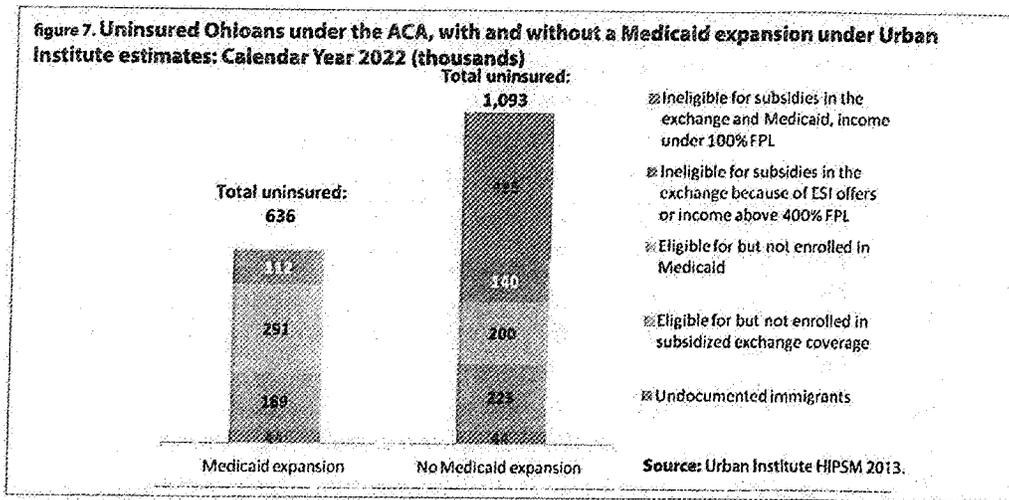
More employment and economic growth

With a Medicaid expansion, many more federal dollars would buy health care from Ohio doctors, nurses, hospitals, and other providers. Those providers will, in turn, purchase other goods and services, much of it from other Ohio businesses. The net result is increased economic activity within the state's borders, creating employment.

figure 6. The number of Ohio uninsured, with and without the ACA, with and without a Medicaid expansion, under OSU estimates (thousands)



Source: OSU 2013. FY 2014 results are for January through June 2014.



To assess these affects accurately, we considered not just the increased federal Medicaid dollars that would result from expansion but also the reduction in federal HIX subsidies, since a Medicaid expansion would eliminate HIX subsidy eligibility for people between 100 and 138 percent FPL. Even taking this into account, we found that a Medicaid expansion would:

- As of FY 2015, the end of the coming biennium, create between 23,000 (Urban) and 28,000 (OSU) new Ohio jobs, both in health care and other industries;
- Increase the earnings of Ohio residents by between \$17.5 billion (Urban) and \$16.7 billion (OSU) over the entire FY 2014-2022 period; and
- From 2014 to 2022, increase total economic activity in Ohio by between \$19.8 billion (Urban) and \$18.6 billion (OSU) (Tables 10 and 11).

We did not seek to analyze whether the ACA, as a whole, will help or harm the economy, a hotly contested issue on which opinions differ. Rather, we focused on the narrow question raised by the specific policy choice that is before the state's leadership: namely, if the Medicaid expansion were added to the rest of the ACA, would that strengthen or weaken Ohio's economy? Using two different projection methodologies from the Urban Institute and OSU to "feed into" REMI's macroeconomic model for Ohio, we find a clear positive impact of expansion on the state's employment and economic growth.

Lower health care costs for Ohio businesses and residents

Without a Medicaid expansion, employers will pay

more for health care. Some poor or near-poor workers who, under the ACA's original design, were slated to be enrolled in Medicaid will instead sign up for their company's health plan. From FY 2014 through FY 2022, a Medicaid expansion would thus save a total of \$1.7 billion for the state's employers (Table 12). Also, under the ACA, employers with over 50 full time employees can experience penalties if they do not offer coverage or offer coverage that is deemed to be unaffordable. The penalty is triggered when an employee receives a premium tax credit for coverage offered through the HIX. Accessing Medicaid coverage does not trigger an employer penalty. Therefore, employers with full time employees with incomes between 100-138 percent FPL could experience increased penalties if Medicaid is not expanded.

An even greater effect will be felt by poor and near-poor state residents. Without a Medicaid expansion, many who would have joined Medicaid instead will remain uninsured or obtain insurance with cost-sharing well above Medicaid levels. As a result, a Medicaid expansion would lower health care costs for Ohio consumers by an estimated \$7.4 billion over the next nine years (Table 12).

Fiscal gains for counties

Implementing the Medicaid expansion would reduce some counties' health care costs. Many poor and near-poor uninsured, who now receive care funded by local levies, would instead receive Medicaid for which the state and federal governments share financial responsibility.

We were not able to estimate all of these savings,

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table 10. The effects of Medicaid expansion on the Ohio economy under Urban Institute and REMI estimates

Fiscal year	Increased employment	Increased earnings (millions)	Increased economic activity (millions)
2014	9,459	\$487	\$663
2015	22,657	\$1,227	\$1,614
2016	28,384	\$1,660	\$2,077
2017	31,210	\$1,963	\$2,348
2018	32,033	\$2,168	\$2,480
2019	31,989	\$2,317	\$2,550
2020	31,599	\$2,429	\$2,594
2021	31,401	\$2,551	\$2,656
2022	31,872	\$2,718	\$2,779
Total		\$17,520	\$19,761

Source: Urban Institute/HIPSM 2013; REMI 2013. Note: Results show the effects of Medicaid expansion, based on increased federal funding buying Ohio health care, including increased federal Medicaid dollars and fewer federal exchange subsidy dollars. Results shown here do not include effects of other ACA provisions.

table 11. The effects of Medicaid expansion on the Ohio economy under OSU and REMI estimates

Fiscal year	Increased employment	Increased earnings (millions)	Increased economic activity (millions)
2014	13,625	\$700	\$949
2015	28,162	\$1,528	\$1,990
2016	29,831	\$1,770	\$2,170
2017	29,712	\$1,908	\$2,223
2018	28,640	\$1,987	\$2,206
2019	28,226	\$2,087	\$2,238
2020	27,435	\$2,148	\$2,239
2021	26,900	\$2,222	\$2,262
2022	27,056	\$2,340	\$2,345
Total		\$16,689	\$18,622

Source: OSU 2013; REMI 2013. Note: Results show the effects of Medicaid expansion, based on increased federal funding buying Ohio health care, including increased federal Medicaid dollars and fewer federal exchange subsidy dollars. Results shown here do not include effects of other ACA provisions. Columns may not total due to rounding.

table 12. The effect of not expanding Medicaid on health care costs for Ohio employers and consumers (millions)⁵

Fiscal year	Increased employer costs, without an expansion	Increased consumer costs, without an expansion
2014	\$9	\$308
2015	\$61	\$657
2016	\$135	\$733
2017	\$191	\$803
2018	\$222	\$865
2019	\$236	\$920
2020	\$252	\$979
2021	\$268	\$1,042
2022	\$285	\$1,109
Total	\$1,659	\$7,415

Source: Urban Institute HIPSM 2013. Note: Columns may not total due to rounding.

which vary greatly among counties. In particular, we could not estimate fiscal gains that would be experienced by the relatively few large, urban counties that currently spend substantial funds providing health care to people who are uninsured and poor. Also, many counties have levies that support mental health and alcohol and drug addiction services. As discussed earlier in this brief, an expansion of Medicaid will reduce the number of uninsured and provide federal funding to cover services that are entirely funded by state and local dollars today. These state and local dollars can then be used to provide services to those who will remain uninsured or provide services that are not a part of a Medicaid benefit package, such as housing or employment supports, or be redirected to other local priorities.

Counties would also achieve revenue gains, only some of which we could estimate. In particular, a

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Table 13. Impact of Medicaid expansion on county sales tax revenue, under UI and OSU models: FY 2014-2022 (millions)

Fiscal Year	UI	OSU
2014	\$9	\$12
2015	\$27	\$32
2016	\$36	\$37
2017	\$43	\$41
2018	\$48	\$43
2019	\$51	\$46
2020	\$54	\$48
2021	\$58	\$51
2022	\$62	\$54
Total	\$387	\$364

Source: Urban Institute HIPSM 2013; OSU 2013. Estimates assume the same revenue lags that apply to state sales taxes. Note: Columns may not total due to rounding.

Medicaid expansion would increase the amount being spent on Medicaid managed care. Counties as a whole receive sales tax revenue equal to 1.35 percent of such premium payments, as noted earlier. Over the FY 2014-2022 period, these increased revenues would total between \$364 and \$387 million (Table 13).

Counties would also experience general revenue gains from the increased economic activity that would result from expansion. As explained earlier, more federal dollars buying Ohio health care increases the purchasing of goods and services in many different sectors. This increases general revenues for counties and the state alike. At this stage of the project, we were not able to provide estimates of these effects at the county level. A forthcoming analysis will work to

project these effects at the regional level and in some specific counties.

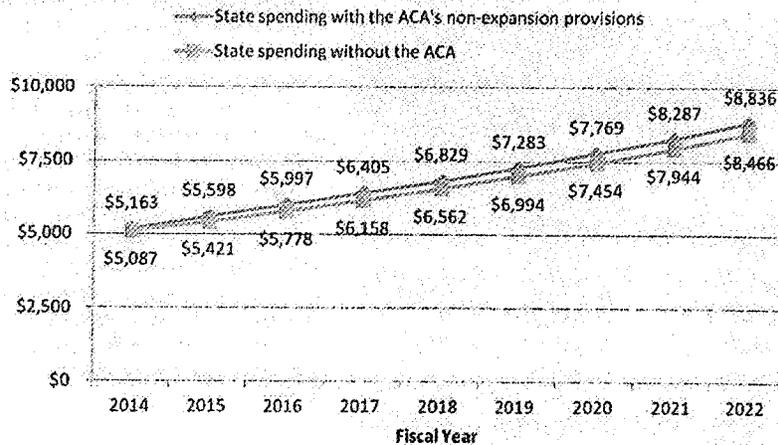
6. What budget effects will the ACA create, even if Medicaid is not expanded?

Without a Medicaid expansion, many of the people who qualify for Medicaid and CHIP but have not enrolled will sign up for coverage, for the reasons described earlier: namely, the ACA's individual coverage requirement; new subsidies in the HIX; increased awareness of the availability of health coverage; the automatic routing of applications from the HIX to Medicaid when applicants appear Medicaid-eligible; other streamlined methods for Medicaid eligibility determination, enrollment, and retention; and general publicity around expanded health coverage.

When currently eligible people enroll in larger numbers, Ohio receives the standard federal matching rate for Medicaid, rather than the highly enhanced rate for newly eligible adults. In addition, the ACA's fee imposed on for-profit insurers will increase state costs for Medicaid managed care arrangements that were in effect regardless of the ACA. Because of these two factors, the state's cost of the ACA, without implementing the expansion, rise from \$90 to \$119 million in FY 2014 to between \$436 and \$457 in FY 2022 (Figure 10).

At the same time, the ACA's non-expansion provisions will result in offsetting state budget gains. Most of those gains are like those described above in connection with the expansion:

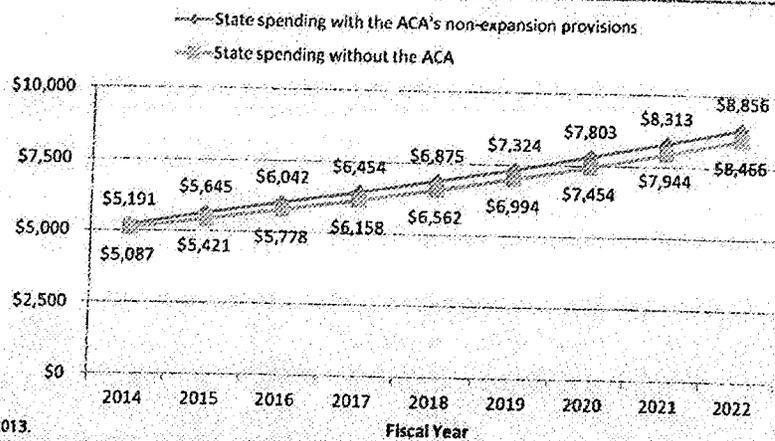
Figure 8. Impact of the ACA's non-expansion provisions on state Medicaid costs resulting from increased participation under Urban Institute estimates (millions)



Source: Urban Institute HIPSM 2013. Note: This figure does not include the effects of the ACA insurer fee.

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figure 9. Impact of the ACA's non-expansion provisions on state Medicaid costs resulting from increased participation under OSU estimates (millions)



Source: OSU 2013.

Note: These estimates include the Urban Institute's baseline projection of state non-ACA Medicaid costs. This figure does not include the effects of the ACA insurer fee.

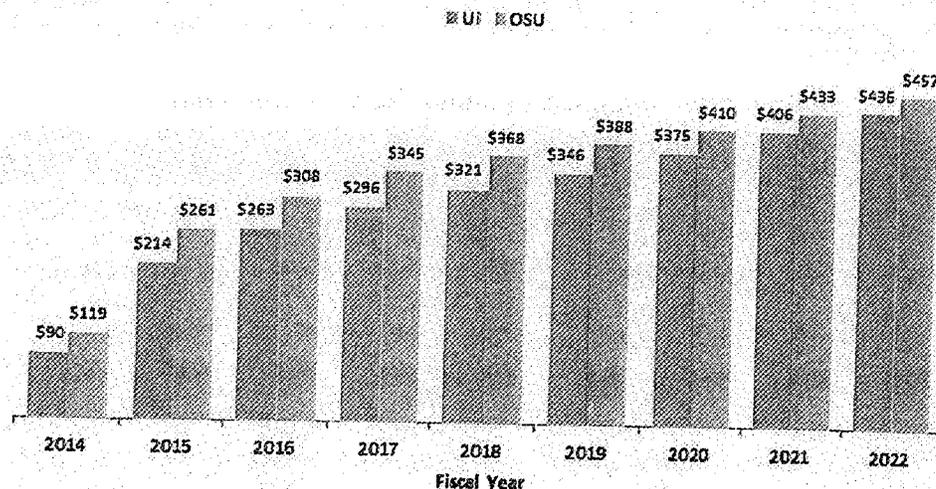
- Increased participation reduces the amount of Medicaid spending on retroactive eligibility;
- When more consumers receive Medicaid, the state receives more prescription drug rebates; and
- With more Medicaid managed care, the state receives additional managed care tax revenue.

However, other offsets are either entirely new or different in character from those that apply to the Medicaid

expansion:

- The ACA increases federal matching rates for CHIP;
 - Subsidized individual coverage in the HIX will provide the state with premium tax revenue; and
 - Federal subsidies in the HIX will purchase considerable Ohio health care, generating economic growth and yielding general state revenue.
- Other potential costs, savings, and revenues could not be estimated, including the following:

figure 10. State budget impact of ACA's non-expansion provisions: cost of increased participation by currently eligible but not enrolled consumers and ACA insurer fee, under UI and OSU estimates (millions)



Source: Urban Institute HIPSM 2013, OSU 2013.

Note: Figure does not include effects of higher federal matching rates for certain current beneficiaries.

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- The administrative cost effects described previously; and
- The potential state savings achieved by moving adults with incomes above 100 percent or 138 percent FPL from Medicaid into subsidized exchange coverage.

Table 14 shows the size of the offsets we could calculate.

Table 15 compares the cost of increased Medicaid enrollment, under the ACA's non-expansion provisions, with the offsets to those costs that result from the increased revenue and state budget savings itemized

above. According to both models, the state costs of the ACA's non-expansion provisions are greater than the savings and revenue offsets. For the entire 9-year period covered by our estimates, these costs exceed the total revenues and savings by between \$20 million and \$185 million from SFY 2014 to SFY 2022.

Taking into account all the above described costs, Table 16 analyzes the impact of the ACA as a whole on the state budget. The first two columns show the effect of the key choice within the control of state officials — namely, whether to expand eligibility. The middle columns show the state budget effects that will occur without an expansion. The two columns on

table 14. Savings and revenue from ACA provisions other than expansion (millions)

Fiscal Year	Retrospective and backdated eligibility	CHIP match increase	Prescription drug rebates		State managed care tax		Premium tax revenue from HIX plans	General state revenue from increased growth		Net offsets to increased costs	
			UI	OSU	UI	OSU		UI	OSU	UI	OSU
2014	\$0	\$0	\$6	\$8	\$8	\$12	\$15	\$22	\$24	\$51	\$59
2015	\$0	\$86	\$19	\$24	\$23	\$32	\$31	\$58	\$61	\$217	\$234
2016	\$16	\$90	\$24	\$28	\$30	\$40	\$33	\$85	\$89	\$278	\$296
2017	\$17	\$94	\$27	\$33	\$34	\$48	\$36	\$103	\$107	\$311	\$335
2018	\$18	\$98	\$29	\$35	\$38	\$52	\$38	\$110	\$115	\$331	\$356
2019	\$19	\$102	\$32	\$37	\$41	\$55	\$40	\$118	\$122	\$352	\$375
2020	\$20	\$107	\$35	\$39	\$44	\$58	\$43	\$124	\$129	\$373	\$396
2021	\$21	\$112	\$38	\$41	\$48	\$62	\$46	\$131	\$135	\$396	\$417
2022	\$22	\$117	\$41	\$43	\$52	\$65	\$48	\$138	\$141	\$418	\$436
Total	\$133	\$806	\$251	\$288	\$318	\$424	\$390	\$889	\$923	\$2,727	\$2,904

Source: OSU 2013; Urban Institute HIPSM 2012; REMI 2013. Note: "UI" refers to Urban Institute estimates. Table does not include possible savings from administrative simplification and possible revenue from increased federal matching funds for eligibility system and shifting higher-income Medicaid adults into subsidized HIX coverage.

table 15. Overall impact of the ACA's non-expansion provisions on the state budget (millions)

Fiscal Year	Increased state costs from more enrollment (figure 10)		Net offset to increased costs (Table 14)		Net fiscal impact	
	UI	OSU	UI	OSU	UI	OSU
2014	\$90	\$119	\$51	\$59	-\$38	-\$60
2015	\$214	\$261	\$217	\$234	\$3	-\$27
2016	\$263	\$308	\$278	\$296	\$15	-\$12
2017	\$296	\$345	\$311	\$335	\$15	-\$49
2018	\$321	\$368	\$331	\$356	\$10	-\$47
2019	\$346	\$388	\$352	\$375	\$6	-\$42
2020	\$375	\$410	\$373	\$396	-\$2	-\$14
2021	\$406	\$433	\$396	\$417	-\$10	-\$16
2022	\$436	\$457	\$418	\$436	-\$18	-\$21
Total	\$2,747	\$3,088	\$2,727	\$2,904	-\$20	-\$185

Note: columns may not total due to rounding.

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table 16. The ACA's impact on the state budget, with and without a Medicaid expansion (millions)

Fiscal year	Impact of the Medicaid expansion (Table 9)		Impact of ACA, without expansion (Table 15)		Net impact of the ACA, with Medicaid expansion	
	UI	OSU	UI	OSU	UI	OSU
2014	\$99	\$113	-\$35	-\$60	\$60	\$53
2015	\$252	\$274	\$3	-\$22	\$255	\$247
2016	\$387	\$384	\$15	-\$12	\$402	\$372
2017	\$351	\$333	\$15	-\$30	\$366	\$323
2018	\$257	\$235	\$10	-\$12	\$267	\$223
2019	\$230	\$208	\$6	-\$33	\$236	\$195
2020	\$142	\$133	-\$2	-\$14	\$140	\$119
2021	\$86	\$69	-\$10	-\$30	\$56	\$53
2022	\$67	\$71	-\$18	-\$21	\$49	\$50
Total	\$1,851	\$1,820	-\$20	-\$165	\$1,831	\$1,635

the right show the combined impact of all the ACA's provisions, if the state adds the Medicaid expansion to the remainder of the ACA.

This analysis of total budget costs, revenues, and savings shows that the net fiscal effects of the ACA as a whole, if the expansion is added, are positive in every state fiscal year. It also suggests that, without a Medicaid expansion, the remainder of the ACA would increase the state's budget deficit by a small amount during FY 2014; but that adding the Medicaid expansion yields a net fiscal surplus for the state of between \$1.6 billion to \$1.8 billion between 2014 and 2022.

From the perspective of state policymakers, however, the most important columns are those on the left of the table. These show the state budgetary impact of the only decision within Ohio control — namely, whether or not Ohio should implement Medicaid expansion.

Medicaid enrollment under the ACA, with and without a Medicaid expansion

Ohio's Medicaid enrollment will increase, even if Medicaid eligibility does not expand. As explained earlier, ACA's non-expansion provisions will cause

Why does the Administration project much higher costs from the non-expansion provisions of the ACA?

The main reason the Administration projects much higher costs is that state-contracting actuaries believe that, even though the ACA's coverage expansions and enrollment mechanisms are limited to people under age 65, seniors who currently qualify for Medicaid but are not enrolled will sign up, prompted by the publicity around health reform. This includes those who receive nursing home care from facilities that already have significant financial incentives to enroll patients into Medicaid after they have spent all their resources paying for care.

Neither the Urban Institute team nor the OSU modelers foresee such effects. They have not materialized in the three states that implemented significant state-based expansions over the past decade: Maine, Massachusetts and Wisconsin. Although the rationale used by the states' actuaries would apply throughout the country, such effects are not forecast by the Congressional Budget Office, the Office of Management and Budget, or the CMS Office of the Actuary.

Note that, in addition to serious questions about whether seniors will be spurred to enroll, there are serious questions about the estimated per capita costs of the seniors who would be affected. The costs projected by the states' actuaries include very expensive nursing home residents, for whom it is particularly implausible to imagine a significant increased enrollment resulting from ACA implementation.

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Table 17. Increased Medicaid enrollment under the ACA, with and without a Medicaid expansion, under UI and OSU models: FY 2014-2022

Fiscal Year	Increased enrollment under the ACA without a Medicaid expansion		Additional enrollment if a Medicaid expansion is added to the rest of the ACA			
			Currently eligible people not enrolled in Medicaid per ACA		Newly eligible adults	
	UI	OSU	UI	OSU	UI	OSU
2014	55,626	80,192	11,551	17,011	153,959	260,360
2015	129,316	174,824	27,036	37,084	380,313	550,050
2016	157,785	203,984	33,271	43,270	497,799	609,264
2017	170,236	219,799	36,100	46,624	570,399	642,354
2018	174,760	221,799	37,150	47,090	603,111	648,777
2019	179,687	224,217	38,121	47,561	612,562	655,265
2020	184,353	266,459	38,932	48,036	621,051	661,817
2021	188,864	228,723	39,782	48,516	629,540	668,436
2022	193,525	231,010	40,571	49,003	638,244	675,120

Source: Urban Institute HIPSM 2012; OSU 2013.

some currently eligible people who are not yet enrolled to sign up for Medicaid. A relatively small additional group of such currently eligible people will join the program if a Medicaid expansion is added to the ACA's other provisions. However, the vast majority of new Medicaid enrollees under an expansion will be newly eligible. Table 17 shows the number and characteristics of new Medicaid enrollees, with and without a Medicaid expansion in Ohio.

Conclusion

The purpose of this study is to assess the comprehensive economic and fiscal effects of Medicaid expansion for Ohio. The report also estimates the net fiscal effects that will occur even without expansion.

Our analysis finds that Medicaid expansion creates net positive state fiscal and economic effects for Ohio in all state fiscal years, including in 2020 and beyond, when the state match rates reaches 10 percent. This finding results from the following specific conclusions:

- Medicaid expansion does generate new state costs, even beginning in SFY 2014. Over the SFY 2014-2022 period, these costs total \$2.4 billion (OSU) to \$2.5 billion (Urban).
- Medicaid expansion also generates substantial state budget savings (\$1.6 billion). These savings result from both increased federal matching rates for current Medicaid spending and from reduced non-Medicaid spending on health care for the poor and near-poor uninsured, who would qualify as newly eligible under expansion.
- Medicaid expansion increases state revenue, even after adjusting for any lost general revenue or managed care tax revenue from fewer people obtaining coverage through the health insurance exchange. Over SFY 2014-2022, the net increase in revenue resulting from expansion totals between \$2.7 billion (OSU) and \$2.8 billion (Urban).
- The combination of budget savings and increased revenues results in Medicaid expansion producing positive net fiscal effects in each state fiscal year, including after the state match rate for newly eligible adults reaches its "steady state" of 10 percent in 2020. The net fiscal gains from expansion, over the 9-year period for which we provide estimates, total between \$1.8 billion (OSU) and \$1.9 billion (Urban). Put simply, Medicaid expansion pays for itself — and creates a positive state budget impact. In addition to paying for itself and creating a positive state budget impact, Medicaid expansion generates several additional benefits to Ohio's economy and Ohioans that would not occur without the expansion, including more than 450,000 uninsured Ohioans obtaining health coverage and more than 27,000 new jobs for Ohio residents.
- Medicaid expansion also creates local fiscal and economic benefits, including between \$364 million (OSU) and \$387 million (Urban) in new local managed care tax revenue

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If Ohio does not expand Medicaid, other ACA provisions will produce net budget shortfalls. However, if the state adds Medicaid expansion to the remainder of the ACA, the state will experience net positive budget effects in every year from SFY 2014 through SFY 2022.

Many aspects of ACA implementation in Ohio are outside state officials' control. But one key choice is in state policymakers' hands—namely, whether to expand Medicaid. Using two very different methods of estimating the effects of that decision, we found adding expansion to the rest of the ACA would improve the state's budget balance, improve the state's economy, and reduce the number of uninsured.

Notes

1. In addition to premium subsidies, cost-sharing subsidies are available for people with income up to 250 percent of FPL.
2. Lawfully present immigrants fall into two groups: so-called "qualified aliens," whose immigration status permits Medicaid eligibility under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); and other lawfully present non-citizens. The largest number of immigrants in the latter category are immigrants whose status has been lawful for less than five years. Medicaid can cover children and pregnant women in this group, but it cannot cover other adults unless they are "qualified aliens." As noted elsewhere in the text, the ACA generally limits tax credits and other subsidies in the health insurance exchange (HIX) to citizens and lawfully present immigrants who are ineligible for Medicaid and CHIP and who have incomes between 100 and 400 percent FPL. There is one exception to the lower income-eligibility threshold, however. Lawfully present immigrants whose immigration status disqualifies them from Medicaid can qualify for HIX subsidies even though their income would ordinarily be too low for HIX subsidies. Accordingly, if Ohio does not expand Medicaid, "qualified aliens," under PRWORA, like citizens, will be ineligible for any help, whether from Medicaid or HIX subsidies, if they are childless adults under 100 percent FPL or parents with incomes between 90 and 100 percent FPL. At the same time, other "lawfully present immigrants," including those whose authorization to live and work in the U.S. has not lasted long enough to qualify for Medicaid, will receive federally-funded HIX subsidies even though they are childless adults living below poverty or parents with incomes between 90 and 100 percent FPL.
3. This likely underestimates savings. With the availability of federal Medicaid dollars for inpatient and institutional care furnished off prison grounds, the state may change its approach to determining which services are furnished on and off prison grounds.
4. Mental Health Advocacy Coalition and Center for Community Solutions. "By the Numbers 2: Developing a Common Understanding for the Future of Behavioral Health Care." November 2012.
5. In SFY 2015, the top ten sectors that will experience a rise in employment because of Medicaid expansion are: ambulatory services (36.1%); hospitals (19.8%); state and local government (7.8%); retail trade (6.1%); administrative and support services (5.3%); construction (5.3%); insurance carriers and related activities (4.0%); food services and drinking places (2.9%); real estate (2.2%) and professional, scientific, and technical services (2.2%).
6. Laura Snyder, Robin Rudowitz, Eileen Ellis and Dennis Roberts. "Medicaid Enrollment: June 2011 Data Snapshot." Kaiser Commission on Medicaid and the Uninsured and Health Management Associates. June 2012. Eileen R. Ellis, Dennis Roberts, David M. Rousseau, Tanya Schwartz. "Medicaid Enrollment in 50 States: June 2008 Data Update." Kaiser Commission on Medicaid and the Uninsured and Health Management Associates. September 2009.

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Ohio Medicaid Expansion Study

About the Ohio Medicaid Expansion Study

The Ohio Medicaid Expansion Study is a partnership of the Health Policy Institute of Ohio, the Ohio State University, Regional Economic Models, Inc. and the Urban Institute, with funding from the Health Foundation of Greater Cincinnati, the Mt. Sinai Health Care Foundation and the George Gund Foundation.

The study was designed to provide an independent, neutral analysis of the impact of potential Medicaid expansion on:

- The state budget
- Ohio economic growth and jobs
- The number of uninsured
- Health coverage, jobs, economic growth, and revenue for regions within the state and some individual counties (to be released in February)





The Supreme Court's ACA Decision and Its Hidden Surprise for Employers
Without Medicaid Expansion, Employers Face Higher Tax Penalties Under ACA

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Key Findings

- States that do not expand Medicaid leave employers exposed to higher "shared responsibility" payments under the Affordable Care Act (ACA).
- The associated costs to employers could total \$876 million to \$1.3 billion each year in the 22 states that have opposed, are leaning against, or remain undecided about expanding Medicaid. By way of example, the decision in Texas to forego the Medicaid expansion may increase federal tax penalties on Texas employers by \$299 to \$448 million each year.
- Any projections of the "net" costs of Medicaid expansions should reflect the very real costs of the shared responsibility penalties to employers in any particular state.

Background and Context

While upholding other provisions of the ACA in June 2012, the U.S. Supreme Court ruled that the federal government could not compel states to expand Medicaid for certain low-income adults. Federal and state law prior to the enactment of the ACA limited Medicaid eligibility to very low income persons who are aged, blind, disabled, minor children, pregnant women and parents. Congress attempted under the ACA to force states to expand Medicaid to all categories of low-income adults under age 65 who were at or below 138% of the federal poverty level (FPL).¹ Under the Court's ruling in *NFIB v. Sebelius*,² though, states now have the option rather than an effective requirement to expand Medicaid to such adult residents.

Coverage options for low income adult residents may be limited in states that do not expand Medicaid. In drafting the ACA, members of Congress assumed that individuals under 138% FPL would be eligible for the Medicaid expansion. They consequently limited access to the

¹ § 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. § 1396a) as added by § 2001(a)(1) of the ACA. While this provision references a 133% FPL income limit, a subsequent amendment to § 1902(e)(14)(l) by § 1004(e)(2) of the Health Care and Education Reconciliation Act (HCERA) of 2012 adds an additional five percent income disregard. For reference, the federal poverty level (FPL) is a construct that varies by household size: 138% FPL in 2013 is \$15,856 for a household of one and \$32,499 for a household of four.

² 567 U.S. ___ (2012).

premium assistance tax credit programs to eligible individuals between 100% and 400% FPL. In states that do not expand Medicaid, then, otherwise-eligible persons under 100% FPL will not be eligible for a subsidized coverage option under the ACA. Those between 100% and 138% FPL would be eligible for the premium assistance tax credits, but they will have to pay a monthly premium for coverage through a qualified health plan.³

The coverage options are also tied to employer penalties. Employers will generally not face penalties because their employees enroll in Medicaid.⁴ Under the "shared responsibility" provisions of the ACA,⁵ though, employers that offer health coverage and have 50 or more full-time equivalent employees must generally pay up to \$3,000 penalties for each employee who enrolls in the premium assistance tax credits. The "shared responsibility" provision also caps an employer's total liability at approximately \$2,000 multiplied by the total number of employees.⁷

Some Governors have expressed concern about the future costs associated with an expansion of Medicaid in their states.⁶ While the ACA ensures that the federal government will pay 100% of the costs of the Medicaid expansion through 2016, states that expand Medicaid become responsible for some portion of the costs thereafter (rising to 10% of the total costs in and after

³ See FAQ #31 in Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "Frequently Asked Questions on Exchanges, Market Reforms and Medicaid" (December 10, 2012), available at <http://ccio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf>, accessed on March 1, 2013.

⁴ Under § 4980H(a) of the Internal Revenue Code, employers with 50 or more full-time equivalent employees will be liable for employer shared responsibility payments if they do not offer coverage and at least one of their employees is eligible for a premium tax credit. In this sense, employers could face penalties for employees who enroll in Medicaid – but the penalty is unrelated to the employee's enrollment in the Medicaid program and is instead triggered by another employee who enrolled in the tax credit program. Also, see note 14.

⁵ § 4980H(b) of the Internal Revenue Code (IRC) as added by § 1513 of the ACA, as amended. See Internal Revenue Service, "Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act," December 28, 2012, available at <http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act> accessed March 1, 2013; Congressional Research Service Report R41159, "Summary of Potential Employer Penalties Under PPACA" (June 2, 2010), available at <http://www.ncsl.org/documents/health/EmployerPenalties.pdf>, accessed March 1, 2013.

⁶ Employees eligible for coverage through their employer may still qualify for the premium assistance tax credits if their employer plan is "unaffordable" in that it costs more than 9.5% of the employee's household income, the plan does not cover the essential health benefit package as defined by HHS, or the plan does not provide "minimum value" (e.g., the plan's deductible and other cost-sharing are too high). § 36B(c)(2)(C) of the IRC as added by § 1501(a) of the ACA, as amended; 77 Fed. Reg. 30377, 30388 (May 23, 2012) (to be codified at 26 CFR § 1-36B-2(c)(3)); 78 Fed. Reg. 7264, 7265 (Feb. 1, 2012) (to be codified at 26 CFR § 1-36B-2(c)). See Congressional Research Service Report R41137, "Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)" (December 30, 2011), available at <http://www.tn.gov/nationalhealthreform/forms/CRS11-12-30.pdf>, accessed March 1, 2013.

⁷ A helpful flow chart in this regard is available from the Kaiser Family Foundation at <http://healthreform.kff.org/the-basics/employer-penalty-flowchart.aspx>. Note that employers that do not offer coverage are subject to a different set of related penalties under § 4980H(a) of the Internal Revenue Code; however, the proportion of employees working at such firms is relatively low. See note 14.

⁸ See, e.g., Letter from Governor Bob McDonnell of Republican Governors Association to President Barack Obama (July 10, 2012), available at <http://www.rga.org/homepage/rga-letter-on-medicaid-and-exchanges-to-president-obama/>, accessed on March 1, 2013.

2020).⁹ These costs have generated substantial discussion among state policy-makers as to the feasibility of such expansions of the Medicaid program.¹⁰

Paradoxically, state government efforts to constrain Medicaid costs growth in and after 2017 may lead to higher net taxes for employers in such jurisdictions beginning in 2014. If a state foregoes the Medicaid expansion, then eligible employees between 100-138% FPL may enroll in the premium assistance tax credits. In such circumstances, their employers will face liabilities for the "shared responsibility" tax penalties discussed above.¹¹

Methods

We used data from Current Population Survey 2011-12 from the U.S. Census Bureau to estimate the number of uninsured adults working full-time under age 65 by state who are between 100-150% FPL. To estimate the number of such individuals who may be eligible to enroll in the premium tax credit programs, we assumed that:

- Persons between 100% FPL and 150% FPL are equally distributed (i.e., they are equally likely to be at 124% FPL as 139% FPL);¹²
- 46% of uninsured individuals who are employed full-time and earn between 100-138% FPL work for companies with 50 or more employees;¹³ and
- 91% of the firms at which these employees work would offer some form of health coverage.¹⁴

Results

⁹ § 1905(y) of the Social Security Act (42 U.S.C. 1396d) as added by § 2001(a)(3)(B) of the ACA and amended by § 1201(1)(B) of the HCERA.

¹⁰ See, e.g., Bovbjerg, Randall, Barbara A. Ormond, and Vicki Chen, "State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts," Kaiser Family Foundation Issue Brief, February 2011, available at <http://www.kff.org/healthreform/8149.cfm>, accessed March 1, 2013.

¹¹ See e.g., Radnofsky, Louise, "In Medicaid, a New Health-Care Fight," *Wall Street Journal*, February 11, 2013, p. A1; Millman, Jason, "Lack of Medicaid expansion could penalize employers," *Politico*, August 29, 2012.

¹² Using this assumption, the proportion of the population below between 100% FPL and 138% FPL would be represented as: # uninsured, full-time employed between 100-150% FPL * (138-100) / (150-100).

¹³ Avalere Health analysis of the Current Population Survey, Annual Social and Economic Supplement, United States Census Bureau, 2012.

¹⁴ Among employees that work at firms with 50+ employees that also have a majority of low-wage workers, 91.4% work at firms that offer health coverage. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2011 Medical Expenditure Panel Survey-Insurance Component, Table I.B.2(2011): Percent of private-sector employees in establishments that offer health insurance by firm size and selected characteristics: United States, 2011 available at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1&year=2011&tableSeries=1&tableSubSeries=B&searchText=&searchMethod=1 accessed March 6, 2013. Employers that offer health coverage would not be subject to broader penalties under § 4980H(a) of the Internal Revenue Code, but they would be subject to penalties for a smaller subset of employees under § 4980H(b).

Applying these assumptions to these data, we estimate that approximately 1.01 million full-time uninsured employees under age 65 could enroll in the premium assistance tax credits. If 100% of such employees were to enroll and no state were to expand Medicaid, the collective employer liability each year for the shared responsibility payments would be between \$2.03 and \$3.04 billion dollars.

Clearly, though, some states are expanding Medicaid. Indeed, the Advisory Board estimates that 24 states and the District of Columbia have moved forward with such expansions, and an additional four states are leaning towards expanding Medicaid. In contrast, 14 states are not expanding Medicaid, while three states are leaning against and another five states are undecided about such expansions.¹⁵ If the 22 opposed and undecided states were to reject the Medicaid expansion and the eligible employees between 100-138% FPL were to enroll in the tax credits, then employers in those jurisdictions may incur liabilities for the shared responsibility penalties of up to \$876 million to \$1.31 billion each year. For reference, we shaded these "expansion averse" or undecided jurisdictions in Table 1 below. Please note, however, that some Governors may have indicated a willingness to expand Medicaid but have not yet received the required legislative authorization (e.g. Florida).

Table 1: Potential Employer Tax Penalties by State

State	100-138% FPL	Eligible for APTCs	Expansion Plans	Potential Employer Shared Responsibility Liabilities (Assuming \$2,000 to \$3,000 per employee)		
US	2,420,017	1,013,019		\$ 2,026,038,299	to	\$ 3,039,057,449
AL	35,429	14,831	No	29,661,092	to	44,491,638
AK	5,288	2,214	Leaning against	4,427,181	to	6,640,771
AZ	54,272	22,718	Yes	45,436,820	to	68,155,230
AR	30,541	12,784	Yes	25,568,590	to	38,352,885
CA	350,377	146,668	Yes	293,335,390	to	440,003,085
CO	32,045	13,414	Yes	26,827,773	to	40,241,659
CT	10,814	4,527	Yes	9,053,514	to	13,580,271
DE	3,905	1,635	Yes	3,269,166	to	4,903,748
DC	1,689	707	Yes	1,413,796	to	2,120,695
FL	174,075	72,868	Yes	145,735,557	to	218,603,335
GA	85,619	35,840	No	71,680,495	to	107,520,742
HI	3,874	1,622	Yes	3,243,078	to	4,864,618
ID	14,724	6,164	No	12,327,134	to	18,490,701
IL	84,291	35,284	Yes	70,568,291	to	105,852,437
IN	43,632	18,265	Undecided	36,529,012	to	54,793,518
IA	15,241	6,380	No	12,759,799	to	19,139,698
KS	19,407	8,124	Undecided	16,247,206	to	24,370,808
KY	38,611	16,163	Leaning toward	32,325,163	to	48,487,744
LA	61,780	25,861	No	51,722,551	to	77,583,826

¹⁵ The Advisory Board Company, "Where each state stands on ACA's Medicaid expansion: A roundup of what each state's leadership has said about their Medicaid plans," available at <http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap#lightbox/1>, accessed March 6, 2013.

State	100-138% FPL	Eligible for APTCs	Expansion Plans	Potential Employer Shared Responsibility Liabilities (Assuming \$2,000 to \$3,000 per employee)	
ME	4,170	1,746	No	3,491,227	to 5,235,667
MD	29,874	12,505	Yes	25,010,580	to 37,515,870
MA	6,885	2,882	Yes	5,763,988	to 8,645,982
MI	64,591	27,038	Yes	54,075,485	to 81,113,227
MN	21,250	8,895	Yes	17,790,165	to 26,685,248
MS	25,966	10,869	No	21,738,869	to 32,608,304
MO	39,867	16,688	Yes	33,376,920	to 50,065,380
MT	11,951	5,003	Yes	10,005,377	to 15,008,066
NE	11,744	4,916	Leaning against	9,832,311	to 14,748,467
NV	21,467	8,986	Yes	17,972,139	to 26,958,208
NH	4,328	1,812	Yes	3,623,569	to 5,435,354
NJ	53,597	22,436	Yes	44,871,810	to 67,307,715
NM	16,751	7,012	Yes	14,024,071	to 21,036,107
NY	110,962	46,449	Leaning toward	92,897,621	to 139,346,431
NC	78,315	32,783	No	65,565,285	to 98,347,927
ND	3,400	1,423	Yes	2,846,681	to 4,270,021
OH	70,441	29,487	Yes	58,973,507	to 88,460,260
OK	41,909	17,543	No	35,085,947	to 52,628,920
OR	26,421	11,060	Leaning toward	22,119,360	to 33,179,040
PA	67,708	28,342	No	56,684,836	to 85,027,254
RI	4,543	1,901	Yes	3,802,998	to 5,704,497
SC	36,368	15,223	No	30,446,888	to 45,670,332
SD	6,469	2,708	No	5,415,947	to 8,123,921
TN	71,153	29,785	Undecided	59,569,693	to 89,354,540
TX	356,627	149,284	No	298,568,091	to 447,852,136
UT	18,527	7,756	Undecided	15,511,039	to 23,266,558
VT	2,355	986	Yes	1,971,807	to 2,957,710
VA	49,917	20,895	Leaning toward	41,790,345	to 62,685,517
WA	50,594	21,179	Yes	42,357,263	to 63,535,895
WV	14,217	5,951	Undecided	11,902,740	to 17,854,110
WI	28,752	12,036	No	24,071,442	to 36,107,163
WY	3,285	1,375	Leaning against	2,749,968	to 4,124,951

Discussion

Our goal was to estimate the order of magnitude of the potential employer liabilities by state. While we acknowledge that data limitations require us to make simplifying analytical assumptions that affect the specific point estimates reported above, we believe these results to be directionally correct.

We have been relatively conservative in our assumptions, though we understand that policy-makers may want to refine the estimates with state-specific data that they may have at their disposal but which are not freely available to the public. For precisely this reason, we have attempted to be fully transparent about our methods.

The actual liabilities that employers incur will depend on the "uptake" or participation rates among eligible employees in the new premium assistance tax credit programs offered through the new insurance exchanges. Because we seek to quantify the potential liability, though, we do not adjust our estimates for estimates of participation rates (which vary widely among experts).

This analysis explicitly excludes employees who are currently insured. Data from the Current Population Survey in 2011-12 suggest that some 2.4 million adults are age 19-64, working full-time, are between 100-150% FPL, and have employer-sponsored health insurance. It is unclear how many of these individuals may drop coverage and migrate to the exchanges and the premium assistance tax credit programs. If this phenomenon were to become widespread, the potential shared responsibility payment liabilities for employers would only increase.

For the reasons discussed above, states that expand Medicaid may effectively lower the penalties for employers that do not provide health coverage. A state's decision to expand Medicaid, though, is unlikely to have a material effect on an employer's incentive to provide employee coverage for several reasons.¹⁶ We acknowledge, though, that Medicaid expansions could theoretically alter the employer's calculus in the provision of health coverage – and policy-makers should at least be aware of this issue.

Conclusion

These estimates suggest that employer liabilities for the shared responsibility payments may be substantial. Such costs could exceed \$1 billion across those states that are now facing the decision about whether to expand Medicaid or that have thus far declined to do so. Any projections of the "net" costs of Medicaid expansions should reflect the very real costs of such liabilities to employers in any particular state.

¹⁶ We believe this to be true for several reasons. First, employer plans cover a much broader group of employees than just those 100-138% FPL. Second, the employer's tax benefits for providing compensation in the form of health benefits remain intact. Third, an employer may not be able to accurately forecast the effect of the Medicaid expansion on the firm because the employer lacks complete information about each employee's household size and income (and cannot therefore estimate the number of employees who fall between 100% and 138% FPL).

Good Morning Chairman Gonzales, Ranking Member Foley and members of the Health & Human Services Subcommittee of the House Finance Committee. I appreciate the opportunity to testify today. My name is Michael Heldman, Hancock County Sheriff, and I am here testifying on behalf of the Hancock County Board of Alcohol, Drug Addiction and Mental Health Services, the Ohio Association of County Behavioral Health Authorities, and the Coalition for Healthy Communities. I am here to testify on behalf of H.B 59 the 14-15 Biennial budget.

As the county sheriff, I see the need for mental health and substance abuse services on a daily basis. Not only have the number of individuals in need increased; but so has the level of severity. The number of cases involving mental illness and/or substance abuse continues to rise. Approximately 27% of all admissions to the jail include a person with a mental illness; and over 40% are there as a result of substance abuse and/or a crime related to substance abuse. For the first time in twenty three years, there was a suicide in our local jail.

I have a long history of working with the Board. CIT has been in place since 2001. This includes training of not only our road officers, but our corrections officers in the jail, and our dispatchers. On site mental health services have been provided since the mid 90's. Beginning in 2011, occupational therapy services have also been delivered on site. These programs are in addition to volunteer services provided from the AA and faith based communities.

Locally, we have worked together to try to improve access to services, especially in light of the severe cuts that were made to the Board in 2009; amounting to over 1.2 million dollars. This has been done through teamwork and the ability to leverage outside dollars from the county commissioners and through the state Attorney General's Office.

The individuals we see through our justice system are in need of multiple services. Many of these individuals are single males, not eligible for Medicaid. Board dollars are currently being used to pay for their primary treatment; leaving little to provide other services such as housing; employment and peer support. Medicaid expansion would go a long way to assist with this problem. At discharge, Medicaid would pick up the primary treatment costs. I urge you to support the proposed budget which includes Medicaid expansion as well as freeing up local Board funds to be used on necessary non-Medicaid services.

Ohio Medicaid Basics 2013

March 2013

HISTORY

Congress created Medicare and Medicaid in 1965 through the Social Security Act. At the time of passage, the programs were heralded as opening "another frontier, that of health security," following the original Social Security Act of 1935 which focused on income security for older Americans.

Medicare focused on health security for older Americans, while Medicaid, known as Title XIX of the Social Security Act, was created to provide health care to certain categories of people who have low incomes and cannot afford health services or health insurance on their own. Over the years, Medicaid coverage has focused on children, parents, and pregnant women, as well as the blind, aged, and disabled.

Medicaid is funded and administered jointly by the state and federal governments. Under broad federal guidelines, states establish their own standards for Medicaid eligibility, benefits, and provider payment rates.

although states must meet certain minimum standards. The federal Centers for Medicare & Medicaid Services (CMS), located within the Department of Health and Human Services (HHS), oversees the Medicaid program.

Medicaid is voluntary for states, but every state participates and administers its own program. Ohio's Medicaid program started in 1968 and is administered currently by the Ohio Department of Job and Family Services (ODJFS).

Medicaid is an entitlement program, meaning that states cannot limit the number of eligible persons enrolled in Medicaid or deny access to medically necessary services to control costs.

In state fiscal year (SFY) 2012, the total expenditure for Ohio's Medicaid program was \$17 billion,² including both state and federal funds. This accounts for about 3.5% of Ohio's economy.³ State funds were \$6.1 billion of the \$17 billion total Medicaid expenditure.

At a glance

- Medicaid...
- Combines federal and state funds to cover vulnerable populations
 - Is Ohio's single largest payer of health care services
 - Is the largest payer of long-term care in the state
 - Covers over one-half of Ohio's youngest children, ages 0-4, and 40% of Ohio's children ages 5-19
 - Covers more than 2.2 million Ohioans with low incomes every month, including children, parents, pregnant women, seniors and certain people with disabilities
 - Contracts with private managed care plans to provide health care to over 1.64 million clients
 - Helps fund hospital care for Ohio's uninsured
 - Supplements Medicare for certain low-income seniors and people with disabilities
 - Is administered in Ohio by the Ohio Department of Job and Family Services/Office of Medical Assistance

The difference between Medicaid and Medicare

Medicaid

- Aid for some low-income and disabled Ohioans
- Eligibility based on income
- Children, parent, disabled and age 65+
- Primary, acute and long-term care
- State and federal funding
- Not funded by payroll deduction

Medicare

- Care for nearly all Ohio seniors
- No income limit
- Age 65+ and some people with disabilities
- Primary and acute care only
- Federal funding (with some premium payments from Part B beneficiaries)
- Funded by payroll deduction

INSIDE

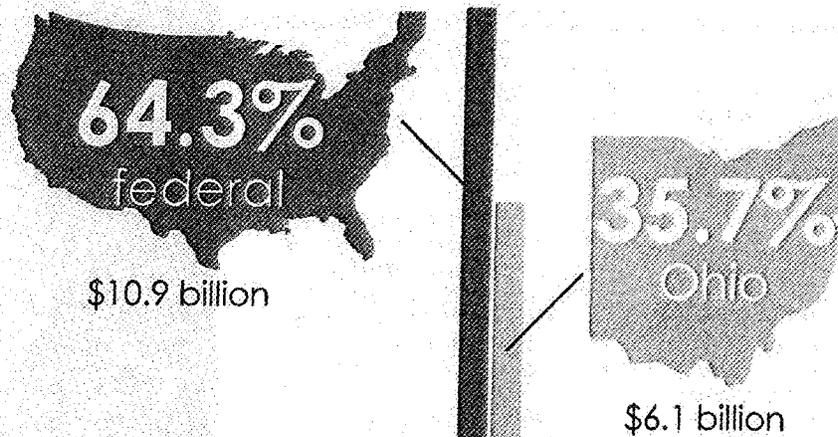
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Who pays for Medicaid?

Total annual Medicaid spending, SFY 2012

\$17.01 billion
(across all Ohio agencies)



Source: CMS-64 Spending across all agencies, SFY 2012; ODJFS Data Run, 1/24/2013. Additional calculations by HPIO.

How much of the state budget does Medicaid represent?

The answer to this question varies depending on which funds are counted. In SFY 2013, Medicaid represents about 25% of the state share General Revenue Fund (GRF) budget. However, because Ohio follows the practice of counting the federal match on Medicaid spending as part of the state GRF—a practice not done with other federal funds—when the federal Medicaid reimbursement is added, Medicaid represents about 45% of the total GRF.⁴

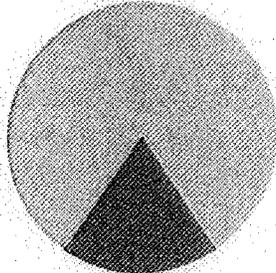
Federal Medical Assistance Percentage (FMAP)

State Medicaid programs receive matching funds from the federal government to help pay for Medicaid services and administration. The Secretary of the Department of Health and Human Services (HHS) calculates these matching funds each year using the Federal Medical Assistance Percentage (FMAP). FMAP is calculated according to a formula contained within the Social Security Act, which takes into account a state's average per capita income relative to the national average. By statute, the FMAP for a state cannot be lower than 50% or more than 83%. FMAP runs according to the federal fiscal year; the 2012 FMAP was effective from October 1, 2011 through September 30, 2012. Ohio's 2012 FMAP was 64.15%,⁵ meaning that for every \$1.00 of state expenditure, the federal government contributed \$1.79.

A higher FMAP, known as "enhanced FMAP" (eFMAP), is used in the Children's Health Insurance Program (CHIP). Ohio's 2012 eFMAP for CHIP was 74.91%,⁶ meaning that for every dollar of state expenditure, the federal government contributed \$2.99. These FMAPs apply to health care costs. Medicaid administrative expenses are shared equally between the federal and state governments (50/50 rate). Medicaid administrative costs were 3.2% of the total Medicaid budget (\$544 million) in SFY 2012.⁷

ENROLLMENT

total 2012 Ohio population
(11.54 million)



19%
(2.21 million)
Average monthly enrollment of Ohioans

Covered families and children (CFC)
1.66 million

Aged, blind or disabled (ABD)
421,000

Other
130,000

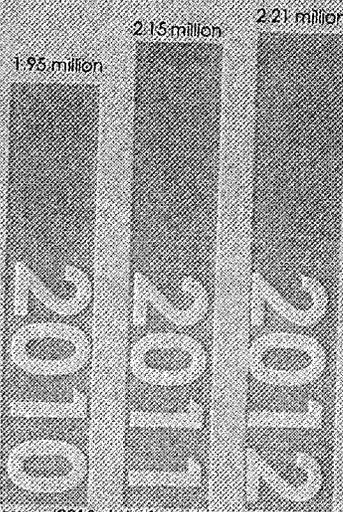
Sources: ODJFS Data Run, 1/16/2013. Ohio population from US Census Bureau. Additional calculations by HPIO.

In SFY 2012, a total of 2.64 million Ohioans were enrolled in Medicaid at some point during the year.⁸ However, because people enter and exit the program throughout the year, Medicaid's SFY 2012 average monthly enrollment was 2.21 million Ohioans.⁸⁹

Because Medicaid eligibility is based on income, changes in the economy have a direct impact on enrollment, especially for children, pregnant women and parents. In addition to the economy, other factors that impact enrollment include:

- Changes in the overall population (demographic changes are driving a steady increase in enrollment for seniors and people with disabilities)
- Policy changes (Ohio's adoption of the family planning option has added new people to the Limited Benefit Medicaid category)
- Rising cost of health insurance in the individual and employer-sponsored market
- Continuing decline in employer-sponsored health insurance

Ohio Medicaid enrollment trend



Source: 2010 data from 2011 Ohio Medicaid Basics; 2011 and 2012 data from ODJFS Data Run, 1/16/2013. Additional calculations by HPIO.

⁸ Compared to the annual unduplicated count, average monthly enrollment is a more accurate reflection of Medicaid enrollment at any given time. In this publication, HPIO uses average monthly enrollment unless otherwise noted.

ELIGIBILITY

In order to qualify for Medicaid coverage, a person must be a U.S. citizen¹⁰ and an Ohio resident, have or obtain a Social Security number, and meet certain income and categorical requirements.

Ohio Medicaid covers low-income children, parents of dependent children, pregnant women, seniors, and people with disabilities. The income level for each category varies, as outlined in the table below.

How does Ohio's eligibility compare to other states?

Population	Ohio Income eligibility	National median	Notes
Children 0-18	200% FPL	235% FPL	25 states cover kids > 250% FPL 17 states cover kids > 300% FPL
Pregnant Women	200% FPL	185% FPL	38 states cover pregnant women > 185% FPL 16 states cover pregnant women > 200% FPL
Parents of dependent children	90% FPL	61% FPL	33 states cover parents < 100% FPL 16 states cover parents < 50% FPL
Adults without dependent children	Does not cover	N/A	9 states offer full Medicaid coverage, 16 states offer limited coverage, 2 states offer both, enrollment is closed in 10 states

Source: "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013." Kaiser Commission on Medicaid and the Uninsured, January 2013. Data is current as of January 2013.

What is FPL? How is it determined?

Federal poverty level (FPL) guidelines were originally calculated in 1963 by the Social Security Administration. The formula was set as three times the cost of food using the USDA economy food plan. FPL is now updated using the change in the Consumer Price Index for the previous calendar year.

2013 Federal Poverty Level (FPL) Guidelines

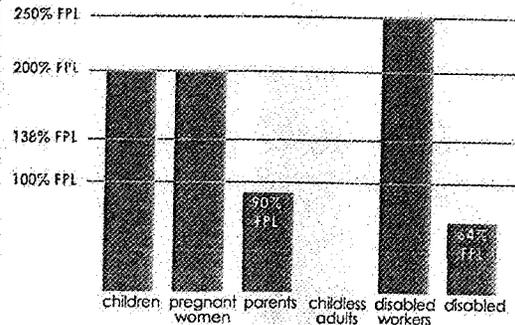
(by household size)

	64%	90%	100%	138%	200%	250%	400%
1	\$7,354	\$10,341	\$11,490	\$15,856	\$22,980	\$28,725	\$45,960
2	\$9,926	\$13,959	\$15,510	\$21,404	\$31,020	\$38,775	\$62,040
3	\$12,499	\$17,577	\$19,530	\$26,951	\$39,060	\$48,825	\$78,120
4	\$15,072	\$21,195	\$23,550	\$32,499	\$47,100	\$58,875	\$94,200

Source: Federal Register, January 24, 2013

Note: Annual guidelines for all states except Alaska, Hawaii and DC. For each additional person, add \$4,020

Current Medicaid eligibility



BENEFIT GROUPS

There are three broad benefit groups in Medicaid, based on eligibility standards: Covered Families and Children (CFC), Aged, Blind and Disabled (ABD) and "other Medicaid."

Covered Families and Children (CFC)

Children up to age 19, parents of dependent children, and pregnant women can qualify for Medicaid based on family income. Families who participate in the Ohio Works First (OWF) cash assistance program are automatically covered by Medicaid. In addition, CFC includes certain youth who may continue receiving Medicaid coverage until age 21, and Transitional Medicaid.¹¹ Children, parents, and pregnant women are generally healthier and less expensive to cover than seniors and people with disabilities. Accordingly, the CFC category represents 75% of Medicaid enrollment and 36% of total Medicaid health care spending.¹²

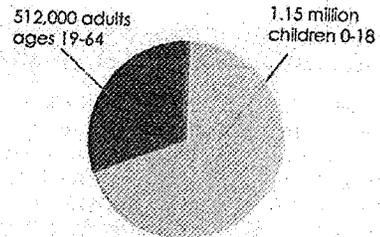


Within CFC, Ohio has several names for the Medicaid program, targeted to two populations:

Healthy Start covers children (up to 200% FPL), youth aging out of foster care (no income limit), and pregnant women (up to 200% FPL). Pregnant women are eligible for Healthy Start coverage during their entire pregnancy and up to 60 days after the baby is born. Babies born to mothers on Healthy Start are automatically eligible for health coverage for one full year from the date of birth, regardless of changes in family income.

Children in families whose income is between 150% - 200% FPL must be uninsured to be eligible for Healthy Start Medicaid. Children in families with incomes under 150% FPL can have other health insurance and still qualify for Medicaid coverage; in those cases, Medicaid acts as the payer of last resort.

In SFY 2012, 1.66 million people were covered under CFC each month:



Source: ODJFS Data Run, 1/16/2013. Additional calculations by HPIO.

Healthy Families covers parents/caregivers and their dependent children who have income up to 90% FPL. These families can have other health insurance and still qualify for Medicaid coverage; in those cases, Medicaid acts as the payer of last resort.

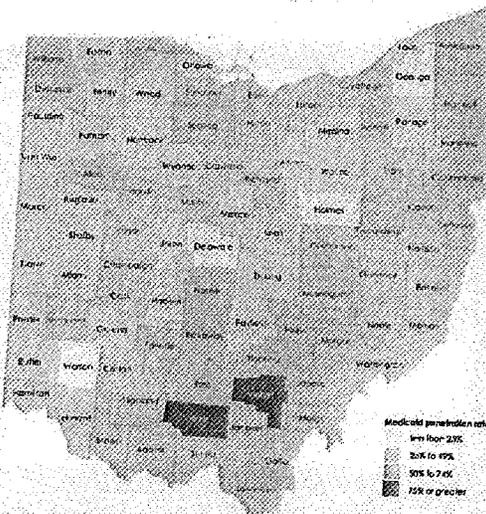
Children and Medicaid

As the largest health insurer of Ohio's children, Medicaid plays a critical role for Ohio's children and families. Consider the following:

- 45% of Ohio births are paid for by Medicaid
- 40% of Ohio's children ages 0-19 are covered by Medicaid
- 53% of Ohio's youngest children, ages 0-4 are covered by Medicaid
- Children ages 0-18 represent 54% of total Medicaid enrollment and about 23% of total Medicaid cost
- Largely as a result of Medicaid coverage, fewer Ohio children are uninsured relative to adults - 8% of Ohio's children are uninsured, compared to 14% of adults ages 19-64

Children enrolled in Medicaid, SFY 2011

Percent of Children Ages 0-4 Enrolled in Medicaid, by County of Residence



Percent of Children Ages 0-19 Enrolled in Medicaid, by County of Residence



Source: ODJFS Data Run, 1/15/2013. Additional calculations by HPIO.

Note: Because these maps use Census data for resident population estimates, the age range is 0-19. Medicaid eligibility for many children is for ages 0-18.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program

The EPSDT program is the federally-mandated package of Medicaid benefits for children. Under EPSDT, states must provide comprehensive health and developmental assessments, as well as vision, dental and hearing services to children and youth up to age 21. The goal of these preventive services is the early identification of conditions that may compromise a child's growth and development. If a potential health problem is found, Medicaid covers the cost of further diagnosis and any necessary treatment. Ohio calls its EPSDT program HEALTHCHEK. A HEALTHCHEK coordinator is available in each county's office of job and family services to help consumers get these services.¹⁸

Children's Health Insurance Program (CHIP)

CHIP was originally established by Congress in 1997 to provide coverage for children living in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. Ohio is one of seven states to implement CHIP as a Medicaid expansion, rather than as a separate CHIP program or a combination of the two approaches. It did so by expanding coverage to children living in families with incomes up to 150% FPL in 1998 and then to children living in families with incomes up to 200% FPL in 2000. In SFY2012, 14% of all Ohio children ages 0-18 covered by Medicaid were covered by CHIP-- an average of nearly 162,000 children per month.¹⁹ CHIP provides an enhanced federal matching assistance percentage (eFMAP) rate for states to cover more children; Ohio's SFY 2012 eFMAP for CHIP was 74.91% (as opposed to the regular FMAP of 64.15%).²⁰

CHIPRA Performance Bonus Grants

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) established a system of bonus payments for states that do an outstanding job enrolling and retaining children in Medicaid. To secure the CHIPRA bonus, a state's enrollment for children in Medicaid must exceed a baseline target and the state must have implemented at least five of eight "simplification" policies that are known to boost enrollment and retention of children. Ohio has received three CHIPRA bonus awards--in 2010, 2011, and 2012-- for a total of \$51.8 million. As of December 2012, Ohio has invested \$15.5 million of these award funds in various initiatives to improve care for all Ohioans.²¹

Aged, Blind and Disabled (ABD)

Ohioans age 65 and older, and people of any age (including children), with a major disabling condition may qualify for Medicaid coverage if they meet certain financial requirements. ABD enrollees have more complex health care needs and are more expensive to cover than the CFC population. Accordingly, the ABD category represents 19% of Medicaid enrollment and 61% of total Medicaid health care spending.²²

When determining eligibility for ABD Medicaid, Ohio counts certain assets including an individual's income, cash, bank accounts, stocks and other assets. Regulations are in place to prevent individuals from improperly transferring assets in order to qualify for Medicaid.²³

People who qualify for ABD Medicaid are covered for the same comprehensive benefit package that is available to children and parents. In addition, those in ABD Medicaid can qualify for Medicaid long-term care services, which include a broad range of medical, personal care, and support services that are provided in home, community, and facility-based settings.

ABD

Among categories within ABD are:

Medicaid Buy-in for Workers with Disabilities (MBIWD): MBIWD was created to encourage Ohioans with disabilities to work by enabling them to keep their Medicaid coverage. Disabled workers ages 19-64 with incomes up to 250% FPL qualify. Those with incomes over 150% FPL are required to pay modest premiums for the coverage.

Medicaid Spend-down: Ohioans with disabilities whose income exceeds the eligibility limit may become eligible on a month-to-month basis through a Medicaid "spend-down." The spend-down allows individuals to deduct medical expenses from their income until they meet financial eligibility guidelines. Once the spend-down is reached, consumers are eligible for Medicaid for the rest of the month.

In SFY 2012, 420,600 people were covered under ABD each month:

Category	Number of People
Adults ages 65+	113,000
Children 0-18	38,400
Adults 19-64	269,200
Total	420,600

Source: ODJFS Data Run, 1/16/2013. Additional calculations by HPIO.

Other Medicaid

Six percent of the Medicaid caseload and 3% of total Medicaid health care spending is in categories other than CFC or ABD, in what this publication refers to as "Other Medicaid." Examples of categories within this subset include Alien Emergency Medical Assistance, Breast and Cervical Cancer Project, certain people who are leaving public institutions (including mental health, youth services, and corrections), presumptively eligible children and pregnant women and deemed newborns.²⁴

The largest "Other" category is known as "Limited Benefits" and includes:

- **(Medicare) Premium Assistance:** Medicaid pays Medicare premiums and, in some categories, cost-sharing for certain consumers covered by Medicaid. An average of 106,000 Ohioans monthly received Medicare premium assistance through this program in SFY 2012.²⁵
- **Family Planning:** Medicaid provides a limited set of benefits for men and women with incomes up to 200% FPL, to help prevent or delay pregnancy. Since full implementation in February 2012, this program has seen significant enrollment, increasing by over 15,000 individuals each month from February through June 2012.²⁶

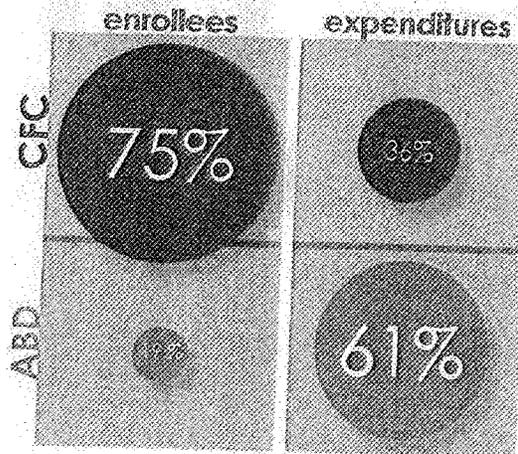
Benefit categories vary widely

Ohio Medicaid serves a wide variety of people with low and modest incomes. Clients range from newborns to elderly nursing home residents, from healthy children to workers with disabilities, from working parents to children with chronic diseases. Because of this, costs for different populations vary widely.

Breast and Cervical Cancer Project (BCCP)

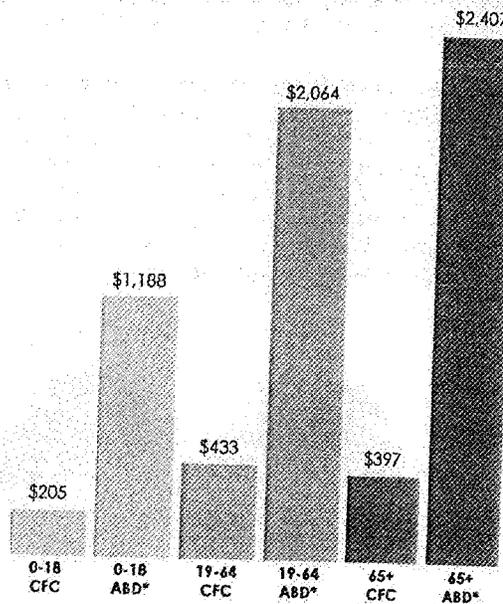
Medicaid provides health care coverage to eligible women screened through the Ohio Department of Health's Breast and Cervical Cancer Project. To qualify, women must have income below 200% FPL and be between the ages of 19-65 and uninsured. Once screened and diagnosed as having breast or cervical cancer, BCCP Medicaid may be available to women who are in need of treatment services. Women who are covered by BCCP Medicaid have access to the full Medicaid benefit package in addition to their cancer treatment.

Cost differences between types of enrollees, SFY 2012



Source: ODJFS Data Run, 1/16/2013. Additional calculations by HPIO. Note: Payment for SFY 2012 is not complete. Services for sister agencies (those outside ODJFS) are included, but due to data issues, only the federal portion of the payment is reflected in the data.

Average monthly Medicaid costs per enrollees, SFY 2012



Source: ODJFS Data Run, 1/16/2013. Additional calculations by HPIO. Notes: Because many Medicaid consumers are not enrolled for a full 12 months, these numbers should not be used to estimate annual costs per person. These costs are shared by the federal and state government. Services from Sister State Agencies are included, but due to data issues, only the federal portion of the payment is reflected in this data.

*ABD in this analysis includes MBIWD and excludes dual eligibles

LONG-TERM CARE

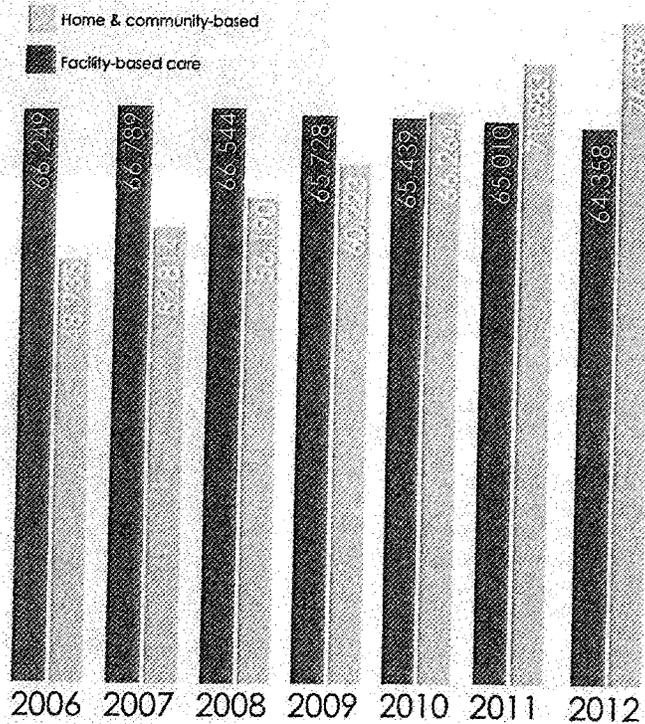
Within Ohio Medicaid, long-term care services can be either facility-based, or home and community-based.

Facility-based long-term care services are provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IID, formerly known as ICF-MR, intermediate care facilities for the mentally retarded (ICF-MR)), and state-run developmental centers for the developmentally disabled.

Home and community-based services (HCBS) allow people with disabilities and chronic conditions to receive care in their homes and communities instead of in long-term care facilities, hospitals or intermediate care facilities. Home and community-based services are waiver programs because under current federal law, eligible people with disabilities and chronic conditions are entitled to facility-based care, but home and community-based care are considered optional. Therefore states must apply for a waiver from the federal government in order for Medicaid to provide home and community-based services.

Compared to other states, Ohio Medicaid typically has delivered a higher proportion of long-term care through facility-based services, leading to greater expense and less consumer satisfaction. For many years Ohio has worked to rebalance the mix of long-term care and encourage Medicaid consumers to choose more cost-effective home and community-based services.

People Served in Long-Term Care Institutions Compared to Home and Community-Based Waivers

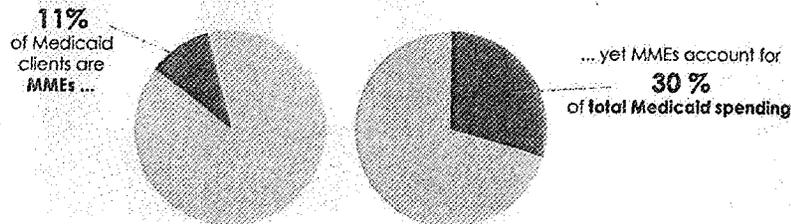


Source: ODJFS Data Run, 1/15/2013.

Note: Average monthly numbers of residents and waiver recipients

Medicare-Medicaid Enrollees (MMEs) (dual eligibles)

Formerly known as "dual eligibles," Medicare-Medicaid enrollees (MMEs) are enrolled in both Medicaid and Medicare. Medicare was created in 1965 to cover the medical needs of senior citizens and later was expanded to cover some people with disabilities. However, Medicare's coverage is limited and does not cover long-term care services. Medicaid pays for most of the cost of nursing homes, home and community-based long-term care, and other medical services for low-income people enrolled in Medicare. In addition, Medicaid pays for Medicare premiums, coinsurance, and deductibles for some low-income consumers, and a share of the cost of Medicare Part D pharmacy coverage.



Source: ODJFS Data Run, 1/15/2013. Additional calculations by HPIO. Note: These data include Medicaid costs only, and exclude costs paid for by Medicare and/or other third party liability carriers. Therefore, these do not represent the total cost for Medicare-Medicaid Enrollees.

Coordinating care for MMEs

In December 2012, Ohio reached agreement with the Centers for Medicare and Medicaid Services (CMS) on a new initiative to better coordinate care for MMEs. Known as the Integrated Care Delivery System (ICDS), the project will comprehensively manage the full continuum of benefits for MMEs, including long-term care services and supports, behavioral health services, and physical health services.

Designated as a three-year demonstration project that will eventually reach 10,000 MMEs, Ohio plans to launch the ICDS program in 22 counties on September 1, 2013. Five managed care plans have been selected to help manage and coordinate the care of MMEs in the program. For more information, see materials posted at <http://www.ohio.gov/41RNWV>.

ADMINISTRATION

Medicaid is funded and administered jointly by the state and federal governments. Under broad federal guidelines, states establish their own standards for Medicaid eligibility, benefits, and provider payment rates, although states must meet certain minimum standards. The federal Centers for Medicare & Medicaid Services (CMS), located within the Department of Health and Human Services (HHS), oversees the Medicaid program.

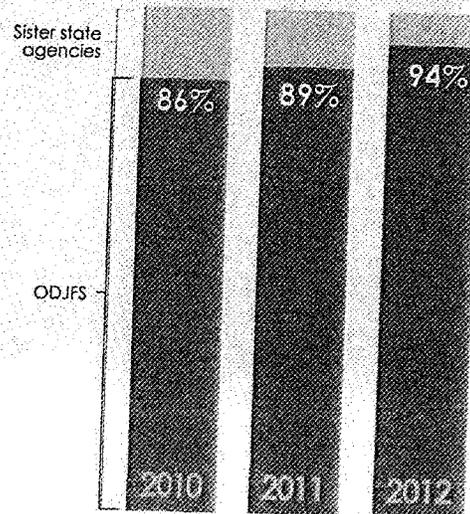
The federal government requires each state to designate a "single state agency" to administer its Medicaid program. Ohio's single state agency is the Ohio Department of Job and Family Services (ODJFS). Within ODJFS, the Office of Medical Assistance (OMA) (formerly known as the Office of Ohio Health Plans) is responsible for day-to-day management of Medicaid. Ohio plans to elevate Medicaid to a cabinet-level agency effective July 1, 2013.

In January 2011, Governor Kasich created the Governor's Office of Health Transformation (OHT). All state agencies that have a role in administering the Ohio Medicaid program directly report to OHT. More information about OHT can be found at www.healthtransformation.ohio.gov.

ODJFS delegates authority to five state agencies (known as "sister state agencies") to administer some Medicaid programs. As a result, Medicaid is included in the budgets of Ohio Departments of Aging (ODA), Alcohol and Drug Addiction Services (ODADAS), Developmental Disabilities (ODODD), Health (ODH), and Mental Health (ODMH). Ohio's 2012-2013 biennial budget transitioned some Medicaid budget line items between ODJFS and sister agencies; most notably, the Department of Aging Medicaid budget moved to ODJFS in SFY 2012. As a result, the majority of Medicaid financing continues to be handled through ODJFS, but the proportion is changing.

Beginning in SFY 2012, the financial responsibility for the non-federal share of Medicaid funds for alcohol and drug treatment and mental health carve-out benefits²⁹ transitioned from community behavioral health boards to the state. Full integration occurred in SFY 2013. This transition is known as "elevation" of Medicaid behavioral health financing to the state level.

Percent of state spending on Medicaid paid by ODJFS



Source: ODJFS Data Run, 1/15/2013. Additional calculations by HPIO.
Note: The Aging budget moved to JFS in SFY12. Remainder of expenses paid by Ohio Departments of Developmental Disabilities, Mental Health, Alcohol and Drug Addiction Services, Aging and Health. Amounts exclude transfers (i.e., sister agency spending), administration, and Department of Aging for SFY10/11. The amounts for SFY 2012 also include HCAP and Supplemental payments not included in previous years.

MANDATED AND OPTIONAL SERVICES

Ohio's Medicaid program includes services mandated by the federal government plus optional services the state chooses to provide. Ohio has some discretion to vary the covered services but by federal law, in all cases, a service must be "sufficient in amount, duration, and scope to reasonably achieve its purpose."³⁰ Some services are limited by dollar amount, the number of visits per year, or the setting in which they can be provided. Some services require the consumer to share in the cost.

Federally mandated services	Ohio's optional services
<ul style="list-style-type: none">• Ambulatory surgery centers• Certified family nurse practitioner services• Certified pediatric nurse practitioner services• Family planning services and supplies• Healthcheck (EPSDT) program services• Home health services• Inpatient hospital• Lab and x-ray• Medical and surgical dental services• Medical and surgical vision services• Medicare premium assistance• Non-emergency transportation to Medicaid services• Nursing Facility care• Outpatient services including those provided by Rural Health Clinics and Federally Qualified Health Centers• Physician services	<ul style="list-style-type: none">• Ambulance/ambulette• Chiropractic services• Community alcohol and drug addiction treatment• Community mental health services• Dental services• Durable medical equipment and supplies• Home and Community-Based Services Waivers• Hospice care• Independent psychological services• Intermediate Care Facility services for Individuals with Intellectual Disabilities (ICF/IID)• Occupational therapy• Physical therapy• Podiatry• Prescription drugs• Pregnancy related services• Private duty nursing• Speech therapy• Vision care, including eyeglasses

Source: ODJFS, "Covered Services," <http://fs.ohio.gov/OHP/consumers/benefits.stm>

MEDICAID COPAYMENTS

Certain medical services require a copayment, including visits for non-emergency services obtained in a hospital, dental services, routine eye examinations, eyeglasses, most brand-name medications, and medications that require prior authorization.³¹

Not all Medicaid consumers are subject to copayments. Consumers are exempt if they meet at least one of these conditions³²:

- Younger than age 21
- Pregnant, or pregnancy ended within the previous 90 days
- Living in a nursing home or intermediate care facility for the mentally retarded
- Receiving emergency services
- Receiving family planning-related services
- In a managed care plan that does not charge copayments

DELIVERY SYSTEM

Ohio Medicaid provides primary and acute care services through managed care plans and a fee-for-service system. Both delivery systems provide preventive services as well as medically necessary primary care, specialty and emergency care services. Historically, Ohio has provided long-term care services exclusively through the fee-for-service system; however, that is changing with the establishment of the Integrated Care Delivery System for Medicare-Medicaid enrollees, which will be administered through managed care plans.

Managed care

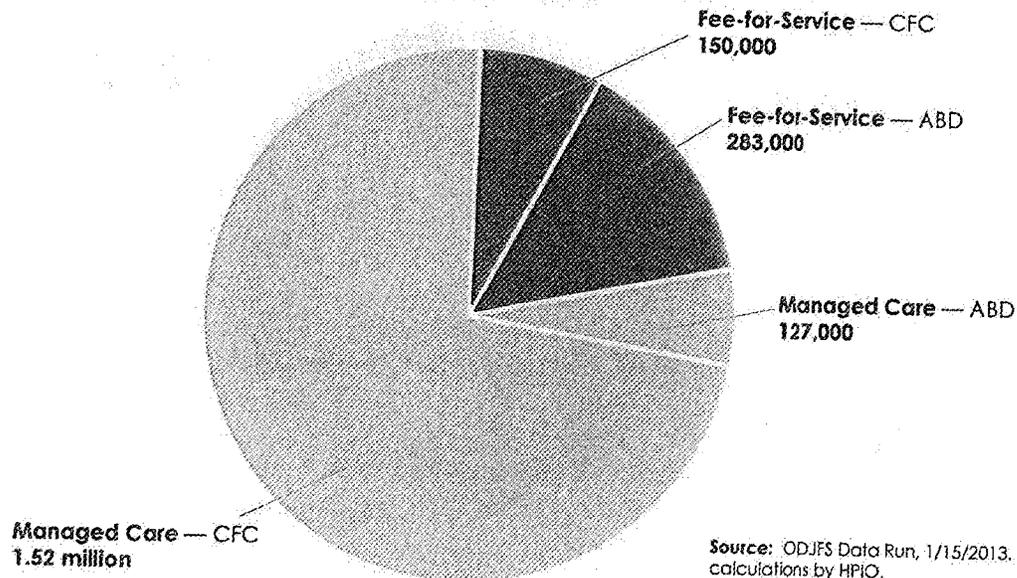
Ohio's Medicaid managed care program was created in 1978 and continues today as a strategy to ensure access to services, provide quality care and manage Medicaid costs. A managed care plan (MCP) is a private health insurance company that provides, or arranges for someone to provide, the standard Medicaid benefit package to Medicaid enrollees. ODJFS contracts with a selected set of managed care plans to coordinate care for Ohio Medicaid enrollees in exchange for a capitation payment – a set amount of money per member per month. The MCP, not the state, is then at full risk for covering any costs that exceed the capitation payment it receives from Medicaid. MCPs control quality and cost by coordinating care through a network of providers selected by the plan. MCPs provide services in addition to the traditional Medicaid benefit package as a strategy to emphasize prevention and ensure that medical services are provided in the most appropriate settings.

Almost all children, pregnant women, and parents enrolled in the Covered Families and Children (CFC) category are required to enroll in a managed care plan. In SFY 2012, 1.5 million CFC clients were enrolled in an MCP, representing 91% of the total CFC population.³³ By contrast, not all those enrolled in ABD Medicaid are required to enroll in a MCP; in SFY 2012, 127,100 ABD clients, were enrolled in an MCP, representing 31% of the total ABD population.³⁴

For a list of consumers who are excluded from, or not required to enroll in, Medicaid managed care, see <http://1.usa.gov/2uCs2S>

Ohio is moving to place more ABD consumers into Medicaid managed care. As noted earlier, the Integrated Care Delivery System (ICDS) project will use Medicaid managed care plans to manage and coordinate care for 114,000 MMEs (dual eligible), starting in September 2013. Effective July 2013, Ohio will transition the 38,000 children currently enrolled in ABD Medicaid into Medicaid managed care plans.

Medicaid enrollment by delivery system, SFY 2012



Ohio Medicaid has gone through a process of re-procuring Medicaid managed care contracts, intended to improve quality and health outcomes for consumers. The new contracting period, effective July 1, 2013, reduces the number of managed care service regions from eight to three and combines coverage for ABD and CFC in each region. Five Medicaid managed care plans will provide health services to Ohio Medicaid consumers. New health plan contract language, based on model health plan contract language created by Catalyst for Payment Reform,³⁵ is intended to move the Medicaid managed care plans from paying for volume to paying for value. (For more information about Ohio Medicaid managed care, see <http://jfs.ohio.gov/ohp/bmhc/index.stm>)

Fee-for-Service (FFS)

Consumers who are excluded from, or not required to enroll in Medicaid managed care receive Medicaid services through the fee-for-service system (FFS). Under FFS, Medicaid providers are paid for particular services based on a pre-set schedule of payment. The FFS system operates statewide so a Medicaid enrollee can go to any of the more than 84,000 Ohio Medicaid providers, including hospitals, doctor offices, pharmacies, dentists, and durable medical equipment companies. These providers are authorized to provide health care services to Medicaid enrollees and to bill Medicaid for these services. However, a provider's participation in the Medicaid program is voluntary, and many providers limit the number of Medicaid clients they serve, so enrollees are advised to ask the provider if they accept Medicaid before scheduling an appointment.

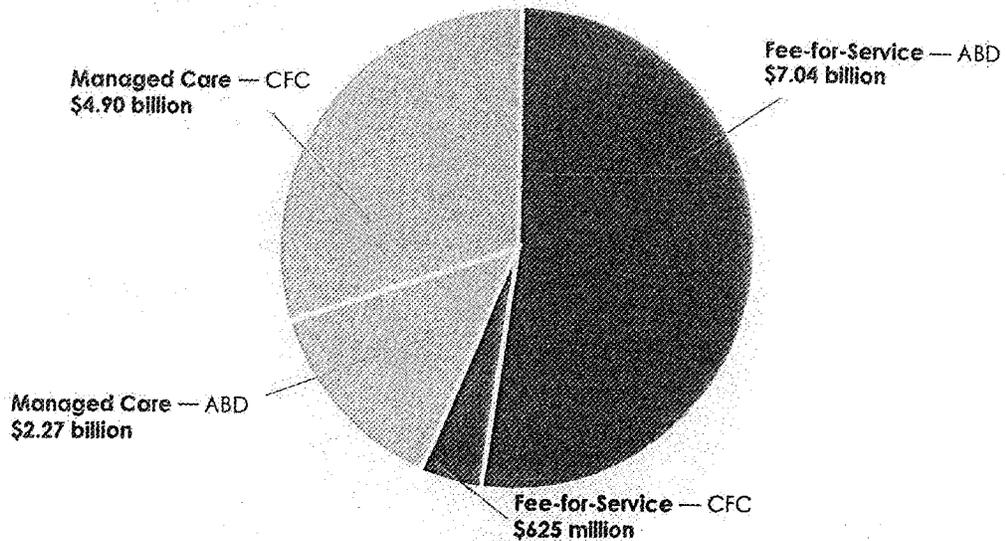
Generally, FFS enrollees are more expensive per person than individuals enrolled in managed care, because many require high-cost, long-term care services, which are excluded from managed care. As a result, the FFS population represents 21% of total Medicaid enrollment and 52% of total Medicaid health care spending.³⁶

Changes ahead for the Hospital Care Assurance Program (HCAP)

Current federal law requires states to operate a Disproportionate Share Hospital (DSH) program that partially reimburses hospitals for uncompensated or free care provided to low-income and uninsured patients, including patients covered by Medicaid.³⁷ Ohio's DSH program, called the Hospital Care Assurance Program (HCAP), is funded by a tax on hospitals, which is used to draw down federal Medicaid matching funds. In exchange for this funding, HCAP requires Ohio hospitals to give free necessary medical care to people who are uninsured with incomes up to 100% FPL.³⁸ Many Ohio hospitals also provide charity care to low income individuals above 100% FPL.³⁹

Due to the expected decrease in the number of uninsured people as a result of health reform, the Affordable Care Act (ACA) reduces DSH payments to hospitals by \$18.1 billion over six years. From 2014 through 2020, payments are reduced to 75% of their current level with funds added back depending on a state's overall uninsured rate decrease.⁴⁰

Medicaid spending by delivery system, SFY 2012



Source: ODJFS Data Run, 1/15/2013. Additional calculations by HPIO.

Medicaid provider rates

Historically, Medicaid pays providers at rates lower than both private insurance and Medicare. Low payment rates are a primary barrier to provider participation in Medicaid.⁴¹ In 2011, 72% of office-based physicians in Ohio accepted new Medicaid patients.⁴² As of 2012, Ohio Medicaid's payment rate for fee-for-service was 61% of Medicare rates for all services.⁴³ The rates that Medicaid managed care plans pay most providers are negotiated between the plan and the provider and can vary from fee-for-service rates. Medicaid managed care plans are required to maintain a "sufficient number, mix and geographic distribution of providers and services."⁴⁴

The Affordable Care Act (ACA) provides a fully federally-funded Medicaid payment rate increase for primary care services to 100% of Medicare payment levels in 2013 and 2014.⁴⁵ This increases payments for primary care services in Ohio by more than 70% in 2013.⁴⁶ The rate increase is meant to encourage greater physician participation in Medicaid and give additional support to those currently providing primary care services to Medicaid patients.

The rate increase applies only to certain providers who deliver primary care services⁴⁷ and is only for 2013 and 2014. States have the option to continue the rate increase beyond 2014 with state funds.⁴⁸

Ohio Medicaid Quality Strategy⁴⁹

The Ohio Medicaid quality strategy is driven by three goals:

- **Better Care:** Improve overall quality by making health care more patient-centered, reliable, accessible and safe.
- **Healthy People/Healthy Communities:** Improve the health of the Ohio Medicaid population by supporting proven interventions to address behavioral, social and environmental determinants of health.
- **Best Evidence Medicine:** Facilitate the implementation of best clinical practices to Medicaid providers through collaboration and quality improvement science approaches.

Ohio Medicaid has identified the seven most costly and prevalent conditions among the Medicaid population. These clinical focus areas drive the overall quality strategy. For example, a portion of Medicaid payments to managed care plans are linked to improved outcomes for the clinical focus areas. In addition, there are specific initiatives in place to address each of the clinical focus areas, which use quality improvement science to promote the adoption of best clinical practices more widely.

Medicaid and Health Outcomes

Evidence regarding the impact of Medicaid coverage on health outcomes is varied and emerging. Some studies show that patients on Medicaid fare worse than those with private insurance^{51,52,53} and, in some cases, worse than those with no insurance⁵⁴. Other studies have demonstrated positive health outcomes related to Medicaid coverage.^{55,56,57} When reviewing available research, it is important to assess the following:

- **What is the comparison?** Is the study comparing Medicaid coverage vs. no coverage, or Medicaid coverage vs. private insurance, or both?
- **For what variables does the study control?** Comparisons between people with Medicaid and other populations are difficult because it is challenging to fully control for differences between groups (e.g., income, baseline health status, community/family supports, access to care, etc.) that directly affect the use of health care and health outcomes. As a result, it can be difficult to differentiate between causation and correlation. More rigorous study designs help to isolate the impact of Medicaid coverage versus other factors.
- **Limitations to generalizing findings.** Medicaid is a large national program, with wide variation among state plans. Variations in geography, local health care environments, features of state plans, and eligibility categories within Medicaid make it difficult to generalize specific study results to other locations or populations.

Because of the inherent challenges of research involving human beings, the research design of Medicaid outcome studies to date have typically been observational or quasi-experimental, rather than randomized controlled trials — the gold standard of medical and scientific research.

That is changing with the advent of the Oregon Health Study,⁵⁸ an ongoing randomized controlled study that compares adults who received Medicaid coverage as a result of a lottery, with those who did not. After the first year, researchers found that relative to uninsured adults with low incomes, new Medicaid recipients had less medical debt, used more health care, and reported better physical and mental health. To date, the only objective health measure is mortality, on which researchers were unable to detect an effect. Data from the second year will include physical health measures such as blood pressure, obesity, cholesterol, and blood sugar control. The results of the Oregon Health Study are specific to the study's population, plan, and health care environment.

CONTROLLING COSTS IN MEDICAID

Reducing provider reimbursement rates and benefit packages are often cited as the only options for reducing Medicaid costs. While states do have the flexibility to use those methods, it is becoming increasingly difficult to do so without compromising the quality and sustainability of the Medicaid program as cuts accumulate.

Many states are implementing initiatives to reduce Medicaid costs and maintain access to quality care for consumers. The table below outlines key strategies identified by the National Governor's Association⁵⁹ and Ohio's efforts.

Strategy	Components	Ohio
Implement managed care contracting policies	<ul style="list-style-type: none"> • Deliver care through managed care plans • Develop performance-based contracts • Competitive bidding contracts • Shared savings models 	<ul style="list-style-type: none"> • In 2012, 91% of CFC and 31% of ABD populations received care through managed care plans • New contract language, based on model health plan contract language created by Catalyst for Payment Reform, is intended to move plans from paying for volume to paying for value • Partners for Kids is a pediatric accountable care organization that serves children covered by Ohio Medicaid and includes a shared savings component⁶⁰
Manage chronic care for complex cases	<ul style="list-style-type: none"> • Identify and address the needs of high-risk, high-cost, and vulnerable populations 	<ul style="list-style-type: none"> • Ohio Medicaid has identified seven high-cost and prevalent conditions which drive the quality strategy (see page 13) • The Medicaid Health Homes project, focusing on individuals with severe and persistent mental illness, integrates physical and behavioral health (see page 15) • The Integrated Care Delivery System will comprehensively manage the full continuum of care for Medicare-Medicaid enrollees (see page 9)
Develop capacity to deliver effective long-term care services	<ul style="list-style-type: none"> • Deliver more long-term care services and supports in home and community-based settings and less in institutions 	<ul style="list-style-type: none"> • Ohio continues to rebalance the mix of long-term care and encourage Medicaid consumers to choose more cost-effective home and community-based services (see page 8) • The 2014-2015 Executive Budget includes plans for Ohio to join the Balancing Incentives Payment Program, which will further the rebalance towards home and community-based care and earn higher reimbursement
Prevent pre-term births	<ul style="list-style-type: none"> • Improve medical interventions to avoid and arrest spontaneous preterm labor • Better management of conditions that lead to medically necessary preterm deliveries 	<ul style="list-style-type: none"> • High-risk pregnancy and premature births are one of the clinical focus areas in the Ohio Medicaid quality strategy. Current strategies include: <ul style="list-style-type: none"> • Elimination of scheduled deliveries prior to 39 weeks • Clinical intervention (antepartum steroids) for high-risk mothers
Manage pharmacy costs	<ul style="list-style-type: none"> • Cost savings and control policies, while continuing to provide adequate access to prescription drugs 	<ul style="list-style-type: none"> • The 2014-2015 Executive Budget includes: <ul style="list-style-type: none"> • New cost-sharing requirements for prescription drugs for certain adults • A new initiative to monitor and implement cost containment strategies for specialty pharmaceuticals
Build capacity to administer program integrity functions	<ul style="list-style-type: none"> • Strengthen the Medicaid Integrity Program by assessing interagency and federal-state coordination and collaboration • Fraud and abuse prevention 	<ul style="list-style-type: none"> • Ohio's Surveillance and Utilization Review Section (SURS) reviews provider paid claims and identifies potential abuse. The 2014-2015 Executive Budget includes: <ul style="list-style-type: none"> • Adding staff to the Medicaid audit team to boost monitoring and recovery capabilities • Stronger efforts to identify overpayments and underpayments • Strengthening pre- and post-payment review of hospital services to inform coverage and utilization management
Payment innovation*		<ul style="list-style-type: none"> • Ohio Medicaid has specific initiatives with key providers including managed care plans, hospitals, and nursing homes to drive paying for value⁶¹ • In January 2012, Ohio Medicaid became the first state Medicaid program to join Catalyst for Payment Reform • In February 2013, Ohio Medicaid was awarded a State Innovation Model (SIM) grant that will be used to develop a comprehensive plan to expand patient-centered medical homes and episode-based payments for acute medical events for most Ohioans on Medicaid, Medicare, and commercial plans

*Payment innovation is not included in the National Governors Association list of strategies, but is known to be an effective strategy for controlling costs.

CURRENT STATE INITIATIVES

Health Homes: Integrating behavioral and physical health

In October 2012, Ohio Medicaid implemented a new person-centered system of care, called a "health home," to improve care coordination for Medicaid clients with serious and persistent mental illness (SPMI). Because individuals with mental illness commonly have serious medical conditions, this model is intended to break down the traditional silos between behavioral health and physical health care. Case managers, located at community behavioral health providers, will coordinate mental health services and assist individuals with obtaining the physical health care they need as well. In addition, they will link clients to supports such as transportation and child care.

Ohio received federal approval for this program (an option included in the Affordable Care Act) in 2012, and the enhanced federal matching assistance percentage (FMAP) of 90%. The first phase includes five Ohio counties (Adams, Butler, Lawrence, Lucas and Scioto); by the end of SFY 2013, the program will be statewide. (For more information on Medicaid Health Homes, see <http://1.usa.gov/Y5hv1p>)

Consolidate mental health and addiction services

Two Sister State agencies, the Ohio Department of Alcohol and Drug Addiction Services and the Ohio Department of Mental Health, will consolidate into the Ohio Department of Mental Health and Addiction Services, effective July 1, 2013. The new department will promote a combined system of care centered on the individual.

A new eligibility and enrollment system

A number of provisions in the Affordable Care Act require states to design and operate coordinated, technology-supported enrollment processes to assist those who lack access to affordable employer-based coverage in obtaining health coverage through Medicaid, CHIP, or the Exchanges.⁶²

New enrollment systems must be in place by October 1, 2013, for coverage that begins January 1, 2014. States must meet these provisions whether or not they expand Medicaid.

The law requires states to develop enrollment systems that are⁶³:

- **Consumer-friendly:** The systems must ensure that applicants are screened for all available health subsidy programs and enrolled in the appropriate program, with minimal collection of information and documentation from applicants.
- **Coordinated:** Programs must be coordinated and there must be seamless transition between all health coverage programs.
- **Simplified:** States must operate a streamlined enrollment process and foster administrative simplification, using uniform income rules and forms as well as paperless verification procedures.
- **Technology-enabled:** States must use Web portals and securely exchange and utilize data to support the eligibility determination.

Designing and implementing a new system by October 1, 2013 will be challenging, but is critically necessary. Ohio's Enhanced Client Registry Information System (CRIS-E), which supports eligibility determination for Medicaid and other public assistance programs, is more than 30 years old. CRIS-E is a patchwork system that prevents automation and can barely meet the needs of Ohio's current Medicaid and human service programs, resulting in duplication, inefficiency and excessive cost for state and local governments to administer Medicaid and other health and human service eligibility processes.⁶⁴ A new system will automate many administrative tasks that currently are handled manually.

Recognizing the information technology (IT) challenges faced by many states, the federal government has provided a time-limited 90 percent federal matching rate for systems development. In March 2012, Ohio received federal approval for the 90% matching funds to build the new system, which will initially be used for Medicaid eligibility then expanded to support eligibility for other public assistance programs.

For more information on Ohio's efforts to modernize eligibility determination systems, see <http://1.usa.gov/ZuJxk7>

Statewide implementation of presumptive eligibility

Presumptive eligibility refers to the process in which certain qualified providers are empowered to perform a simplified eligibility review and grant immediate medical assistance to people applying for Medicaid (currently limited to children and pregnant women). Those determined presumptively eligible must complete the full application process within 60 days to continue Medicaid coverage. Ohio first implemented presumptive eligibility for children in April 2010, relying on county job and family service (JFS) agencies as the qualified provider. In 2012, Ohio expanded presumptive eligibility to pregnant women and added federally qualified health centers and children's hospitals as qualified providers. Statewide implementation is planned for 2013, at which time other entities may be added as qualified providers.⁶⁵

PROPOSED INITIATIVES

Medicaid expansion

Ohio policymakers face a significant policy decision in 2013: whether to expand Ohio's Medicaid program to people with incomes up to 138% of the Federal Poverty Level (FPL),⁶⁶ (\$26,951 annually for a family of three, in 2013).

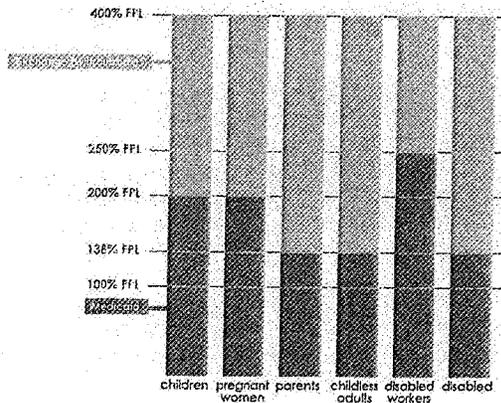
The Patient Protection and Affordable Care Act (ACA), enacted in March 2010, required states to expand Medicaid coverage to individuals with incomes up to 138% FPL. The federal government will pay 100% of the cost for people who are newly eligible for Medicaid from 2014 to 2016, gradually decreasing to 90% in 2020 and beyond. However, in June 2012, the U.S. Supreme Court made expansion of Medicaid optional, rather than required.

Governor Kasich included the Medicaid expansion in 2014-2015 Executive budget, introduced on February 4, 2013. (For an overview of the Governor's proposal, see <http://1.usa.gov/ZBiiYw>) The Executive budget includes an automatic "opt out" trigger that would shut down the program for newly eligible groups if, for any reason, federal funding for expanded coverage is reduced. It is now up to the legislature to debate and decide if Ohio will adopt the expansion.

The graphs below illustrate Ohio Medicaid eligibility with and without the expansion.

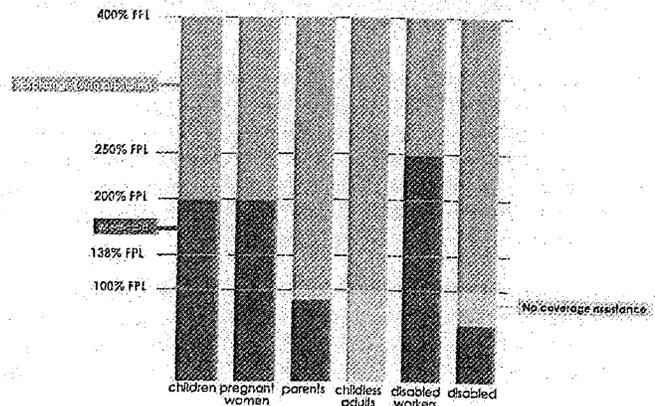
Subsidized health coverage eligibility for Ohioans in 2014

with ACA Medicaid expansion



Subsidized health coverage eligibility for Ohioans in 2014

without ACA Medicaid expansion



The Health Policy Institute of Ohio (HPIO), The Ohio State University (OSU), Regional Economic Models, Inc. (REMI), and the Urban Institute, have partnered on a research study, "Expanding Medicaid in Ohio: Analysis of Likely Effects," to analyze the fiscal impact of a Medicaid expansion on Ohio. (For the expansion study brief, see <http://bit.ly/ZLGk5p> and for HPIO policy brief "Policy Considerations for Medicaid Expansion in Ohio," see <http://bit.ly/13k4O4X>)

Simplify Medicaid eligibility policy

Ohio Medicaid currently has over 150 eligibility categories. The Executive Budget proposes "mapping" those categories into three groups:

1. Children and pregnant women
2. Individuals who are age 65 or older, who have Medicare coverage, or who need long-term care services and supports
3. Community adults — non-pregnant adults who do not need long-term care services and supports, including individuals eligible as parents or caretaker relatives. This category includes those who would be newly eligible for Medicaid, if the proposed Medicaid expansion is adopted.

Eligibility criteria and standards for the first two simplified groups would not change. The third group, community adults, will see significant changes in eligibility standards if the proposed Medicaid expansion is adopted, and a proposed Medicaid benchmark benefit package. (For more details, see <http://1.usa.gov/ZBiiYw>)

New cost sharing requirements

The Executive budget proposes new cost sharing requirements for every adult enrolled in Medicaid over 100% FPL, including:

- \$8 copayment for use of an emergency room for non-emergency conditions
- \$8 copayment for non-preferred drugs
- \$3 copayment for preferred drugs

(Note: certain long-term maintenance drugs, such as insulin, will have no co-pay.)

ACKNOWLEDGMENTS

HPIO thanks Dan Hecht and his colleagues in the Data Research Unit within the Office of Medical Assistance for producing much of the data for this report. Their timely assistance and insight are much appreciated.

GENERAL DATA NOTES

ODJFS data in this report comes from the Decision Support System, during the last week of December 2012. The data is based upon Paid Dates of Service.

Payment data for SFY 2012 is not complete. Services from Sister Agencies (those providing Medicaid reimbursable services which are monitored by an agency other than ODJFS) are included, but due to data issues, only the federal portion of the payment is reflected in this portion of the data.

Unless otherwise noted, enrollment data reflects average monthly enrollment.

The Health Policy Institute of Ohio is an independent organization that is not affiliated with Ohio Medicaid. For questions about the Ohio Medicaid program, please call

1-877-852-0010

or visit

<http://jfs.ohio.gov/Ohp/>



www.hpio.net

GLOSSARY

- Affordable Care Act (ACA)** – The federal health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.
- Aged, Blind, Disabled (ABD)** – A Medicaid eligibility category that includes individuals who are low income and who are aged 65 years or older, blind or disabled (disability as classified by the Social Security Administration for an adult or child).
- Allen Emergency Medical Assistance (AEMA)** – A category of Medicaid that provides coverage for the treatment of an emergency medical condition for certain individuals who do not meet Medicaid citizenship requirements. Only care related to the emergency medical condition is covered; ongoing treatment is not covered.
- Capitation** – A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served without regard to the actual number or nature of services provided to each person in a set period of time.
- Centers for Medicare & Medicaid Services (CMS)** – The federal agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act). www.cms.gov
- Children's Health Insurance Program (CHIP)** – Enacted in 1997, CHIP is a federal-state program that provides health coverage for children who live in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. States have the option of administering CHIP through their Medicaid programs or through a separate program, or a combination of both. Formerly known as SCHIP, or the State Children's Health Insurance Program, the name was changed when the program was reauthorized in 2009.
- Department of Health and Human Services (HHS)** – HHS is the U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Many HHS-funded services, including Medicare, are provided at the local level by state or county agencies or through private sector grantees. The department's programs are administered by 11 operating divisions, including eight agencies in the U.S. Public Health Service and three human services agencies.
- Dual Eligible** – A person who is eligible for two health insurance plans, often referring to a Medicare beneficiary who also qualifies for Medicaid benefits.
- Disproportionate Share Hospital Program (DSH)** – A federal program that works to increase health care access for the poor. Hospitals that treat a "disproportionate" number of Medicaid and other indigent patients qualify for higher Medicaid payments based on the hospital's estimated uncompensated cost of services to the uninsured and underinsured. Ohio's DSH program is called the Hospital Care Assurance Program (HCAP).
- Dual Eligible** – A person who is eligible for two health insurance plans, often referring to a person who is enrolled in both Medicare and Medicaid. (See also Medicare-Medicaid Enrollees.)
- Federal Medical Assistance Percentage (FMAP)** – The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears.
- Federal Poverty Level (FPL)** – Annually updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for various federal and state programs. In 2013, the FPL for a family of four is \$23,550.
- Federally-Qualified Health Center (FQHC)** – FQHCs are community-based and patient-directed organizations that serve populations with limited access to health care. The centers are located in a medically under-served area or population. Centers must meet certain requirements and then are eligible to receive cost based Medicare and Medicaid reimbursement. FQHCs are sometimes referred to as CHCs (Community Health Centers).
- Fee-for-Service** – A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement.
- General Revenue Fund (GRF)** – Resources are allocated by the state for programs from this fund. GRF is composed of all revenues from state taxes, as well as reimbursements from the federal government for some GRF expenditures. Ohio counts the federal match on Medicaid spending as part of the state GRF.
- Health Insurance Marketplace** – (Initially known as Health Insurance Exchanges, or Exchanges) The Health Insurance Marketplace is a competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans, starting January 1, 2014. Exchanges offer a choice of health plans that meet certain benefits and cost standards. The Exchange can set standards beyond those required by the federal government, accept bids, and negotiate contracts with insurers. Under the ACA, states have the option to establish their own marketplaces, allow the federal government to run the marketplace, or partner with the federal government to run the marketplace.

Home and Community-Based Services (HCBS) – Long-term care services provided in a patient's place of residence or in a non-facility-based setting located in the immediate community.

Long-Term Care (LTC) – A set of health care, personal care and social services provided to persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, or disabled) in an institution or at home, on a long-term basis.

Managed Care – Health care systems that integrate the financing and delivery of appropriate health care services to covered individuals. Managed care systems arrange with selected providers to furnish a comprehensive set of health care services.

Medicaid – A joint federal-state program that provides health care for low-income people who meet both income and categorical requirements. Under broad federal guidelines, states establish their own standards for Medicaid eligibility, benefits, and provide payment rates.

Medicaid Health Homes – A coordinated, person-centered system of care. An individual who is eligible for health home services can obtain comprehensive medical, mental health and drug and/or alcohol addiction treatment, and social services that are coordinated by a team of health care professionals.

Medical Home – An approach to providing comprehensive primary care that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need it in a culturally and linguistically appropriate manner.

Medicare – A federally funded health insurance plan that provides hospital, surgical and medical benefits to elderly persons over 65 and certain disabled persons. Medicare Part A provides basic hospital insurance, and Medicare Part B provides benefits for physicians' professional services. Medicare Part C (Medicare Advantage Plan) allows those covered to combine their coverage under Parts A and B but is provided by private insurance companies. Medicare Part D helps pay for medications doctors prescribe for treatment.

Medicare-Medicaid Enrollees (MMEs) – People who are enrolled in both Medicare and Medicaid. (Also known as Dual Eligibles.)

Presumptive Eligibility – The process in which certain qualified entities are empowered to perform a simplified eligibility review and grant immediate medical assistance to people applying for Medicaid (currently limited to children and pregnant women). Those determined presumptively eligible must complete the full application process within 60 days to continue Medicaid coverage.

Sister State Agencies – State agencies that provide Medicaid reimbursable services which are monitored by an agency other than the Ohio Department of Job and Family Services. Sister state agencies include the Ohio Departments of Aging (ODA), Alcohol and Drug Addiction Services (ODADAS), Developmental Disabilities (ODODD), Health (ODH), and Mental Health (ODMH).

Spend-down – Aged, blind and disabled individuals whose income is too high but who would otherwise be eligible for Medicaid may become eligible on a month-to-month basis through a Medicaid spend-down. The spend-down allows individuals to deduct medical expenses from their income until they meet financial eligibility guidelines. Once the spend-down is reached, consumers are eligible for Medicaid for the rest of the month.

Transfer-of-resources – As defined by Medicaid, is a voluntary gift or change of ownership of a resource without receiving fair market value in return. If the transfer has been made during the "look-back" period prior to applying for Medicaid, it is assumed that the transfer was made in order to become Medicaid eligible. In those cases, a penalty period is assessed, during which Medicaid is denied. Transfers of resources between spouses do not generate a penalty. Transfers of resources to children may generate a penalty.

Spend down – The process of establishing eligibility for Medicaid by allowing an individual who would otherwise not be eligible for the program to spend excess net income on certain medical expenses.

Transfer-of-resources – As defined by Medicaid, a voluntary gift or change of ownership of a resource without receiving fair market value in return. If the transfer has been made during the "look-back" period prior to applying for Medicaid, it is assumed that the transfer was made in order to become Medicaid eligible. In those cases, a penalty period is assessed, during which Medicaid is denied. Transfers of resources between spouses do not generate a penalty. Transfers of resources to children may generate a penalty.

Transitional Medicaid – A category of Medicaid in which people who lose Medicaid eligibility due to earned income may be eligible to maintain Medicaid coverage for a transition period of up to twelve months.

Waiver – Authorization by the Secretary of the U.S. Department of Health and Human Services (HHS) to waive certain Medicaid statutory requirements, giving states more flexibility in Medicaid program operation. An example is the home and community-based care (HCBC) waiver programs operated under Section 1915(c) of the Social Security Act that allow long-term care services to be delivered in community settings.

NOTES

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8. ODJFS Data Run, 1/16/2013.
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10. Immigrants who arrived in the U.S. before August 22, 1996 may be eligible for Medicaid if they meet other eligibility guidelines. With certain exceptions, immigrants who arrived on or after August 22, 1996 are not eligible for Medicaid. For a list of exceptions, see "ODJFS Fact Sheet: Immigrants, Their Children, and Medicaid." Downloaded 1/24/2013 at http://jfs.ohio.gov/OHP/bcps/FactSheets/Immigrants_0607.pdf.
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12. Payment data for SFY 2012 is not complete. Only the federal portion of services from Sister Agencies (those outside ODJFS) are included in these figures. Source: ODJFS Data Run 1/16/2013. Additional calculations by HPIO.
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50. The clinical focus areas include: high risk pregnancy/premature births, behavioral health, cardiovascular disease, diabetes, asthma, upper respiratory infections, and musculoskeletal health (for dual eligibles).
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66. Federal Poverty Level (FPL) guidelines are annually updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for various federal and state programs.



Governor's Office of
Health Transformation

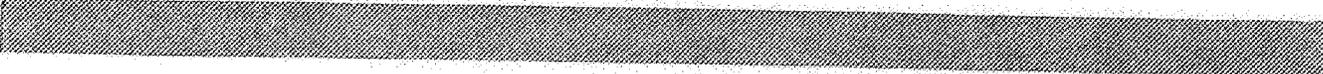
Health Transformation Budget Priorities

House Finance Committee Testimony
February 14, 2013

Ohio's Health Transformation Team

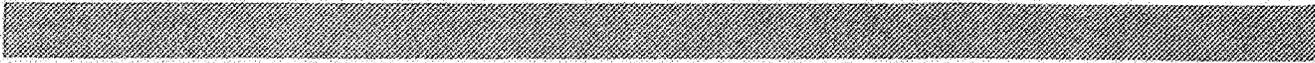
- Greg Moody, Office of Health Transformation
- John McCarthy, Medicaid
- Tracy Plouck, Mental Health
- Orman Hall, Addiction Services
- John Martin, Developmental Disabilities
- Bonnie Kantor-Burman, Aging
- Ted Wymyslo, MD, Health

www.HealthTransformation.Ohio.gov



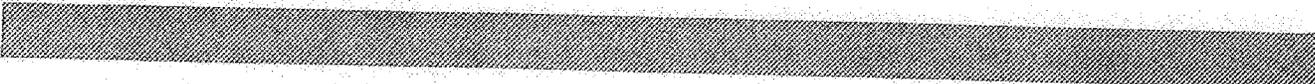
Jobs Budget 2.0 Medicaid Plan

- **Obamacare is not the path Governor Kasich would have chosen for Ohio, but it is – for now – the law of the land**
 - In March 2010, Congress mandated that every state expand Medicaid to adults with annual income below \$15,415 (138% of poverty)
 - In June 2012, the United States Supreme Court ruled the federal government cannot penalize a state that chooses not to expand
- **After weighing the options, Governor Kasich decided that extending coverage to more low-income Ohioans makes sense**
 - Ohio has the legal authority and will automatically roll back the extension if the federal government changes the rules



Extending Coverage Makes Sense for Ohio

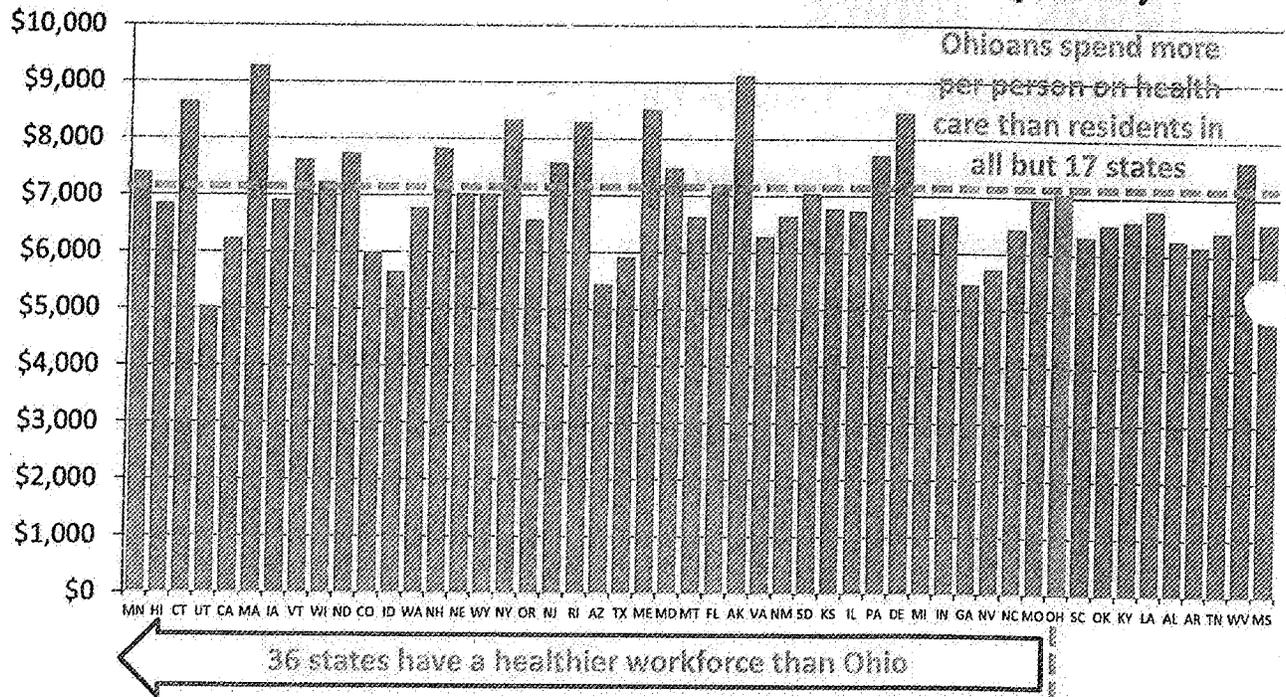
- **Right care, right place, right time – not the emergency room**
 - 275,000 more low-income Ohioans covered
- **Keep Ohioans' federal tax dollars in Ohio**
 - \$2.4 billion over 2 years; \$13 billion over 7 years
- **Strengthen local mental health and addiction services**
 - Free up \$100+ million in local levy dollars
- **Protect local hospitals from federal cuts**
 - Medicaid uncompensated care payments will be cut in half by 2019
- **Provide immediate taxpayer relief in Ohio's budget**
 - Free up \$690 million – \$404 million in state spending – over 2 years



Today's Topics

- Challenges we face in Ohio
- Health Transformation Priorities
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Health Care Spending per Capita by State (2011) in order of resident health outcomes (2009)



Governor's Office of
Health Transformation

Sources: CMS Health Expenditures by State of Residence (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (October 2009).

Governor Kasich's First Jobs Budget:

"Repeal and Replace" Old Medicaid

Inherited a program that grew 33% over 3 prior years

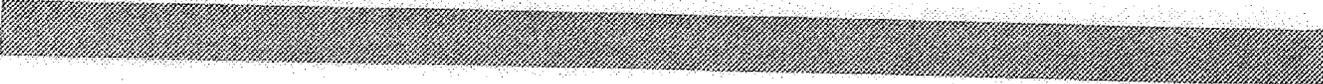
- Created the Office of Health Transformation
- Linked nearly 10% of nursing home reimbursement to quality
- Increased access to home and community based services
- Freed local behavioral health from Medicaid match
- Created health homes for people with serious mental illness
- Consolidated health plan regions to be more efficient
- Linked 1% of health plan payments to performance
- 3rd state approved to integrate Medicare-Medicaid services
- Implemented a new Medicaid claims payment system

Saved Ohio taxpayers \$2 billion over two years



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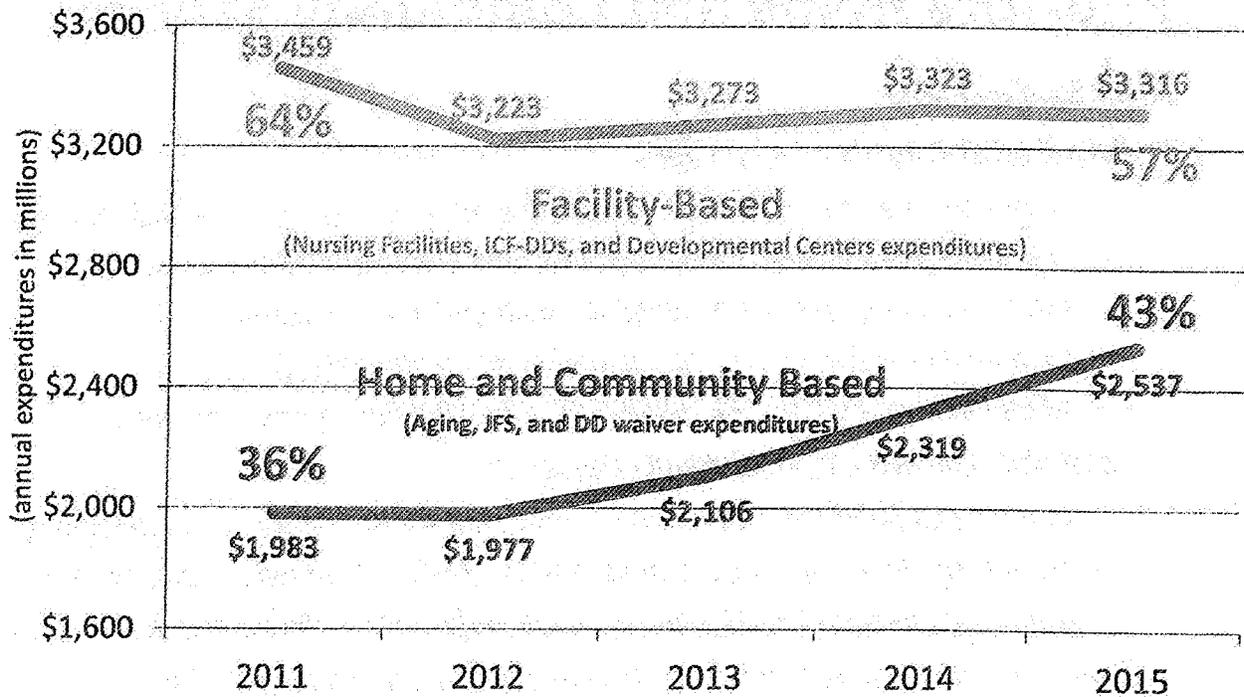
Rebalance Long-Term Care:

Prioritize Home and Community Services

Jobs Budget 2.0

- Medicaid payment changes
 - Increase rates for aide & nursing services, adult day care, assisted living
 - Increase the nursing home resident personal needs allowance
 - Limit the daily rate for a caregiver living with a consumer
 - Implement a shared savings initiative for home health
 - Medicaid net cost is \$31 million (\$11 million state) over two years
- Join the Balancing Incentive Program
 - Commit to 50/50 institutional vs. community long-term care spending
 - No wrong door, standard assessments, conflict-free case management
 - Enhanced federal funds free up \$120 million state share over two years
- Ensure core competencies in the direct care workforce

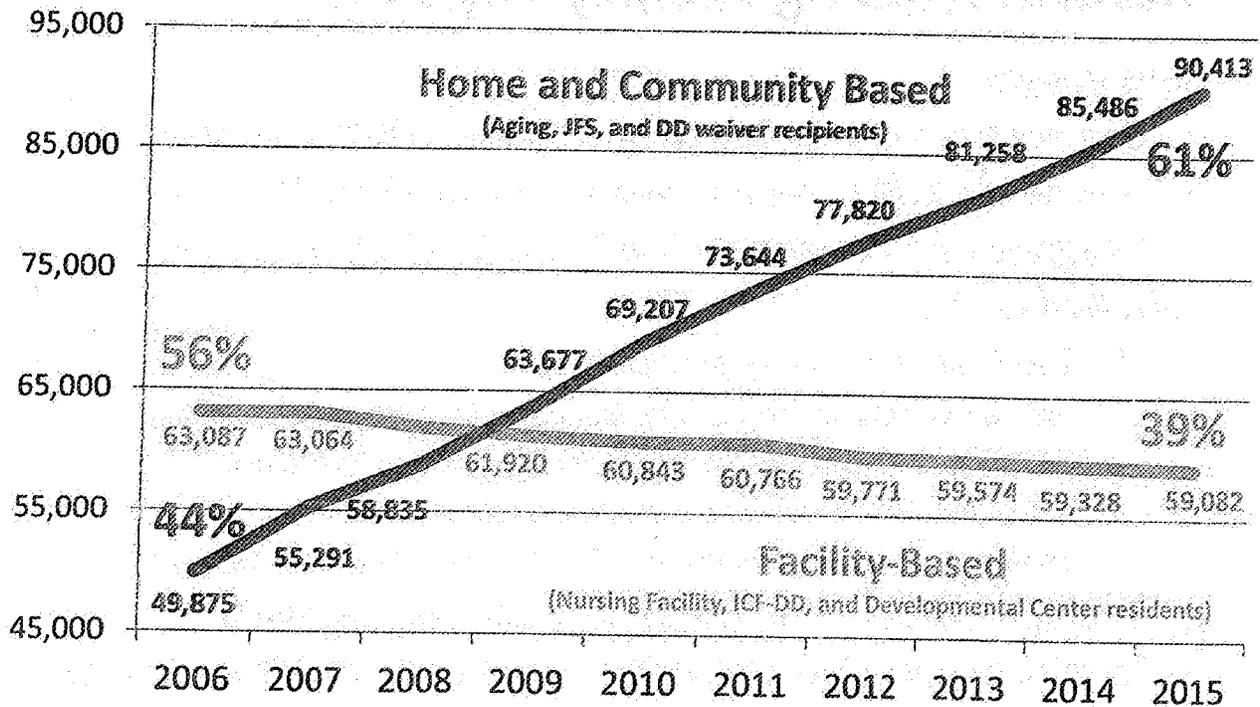
Ohio Medicaid Spending on Institutions Compared to Home and Community Based Services



Governor's Office of Health Transformation

Source: Ohio Medicaid based on agency surveys; 2011-2012 actual and 2013-2015 estimated.

Ohio Medicaid Residents of Institutions Compared to Recipients of Home and Community Based Services



Governor's Office of Health Transformation

Source: Ohio Medicaid based on agency surveys; 2006-2012 actual and 2013-2015 estimated.

Rebalance Long-Term Care:

Reform Nursing Facility Payments

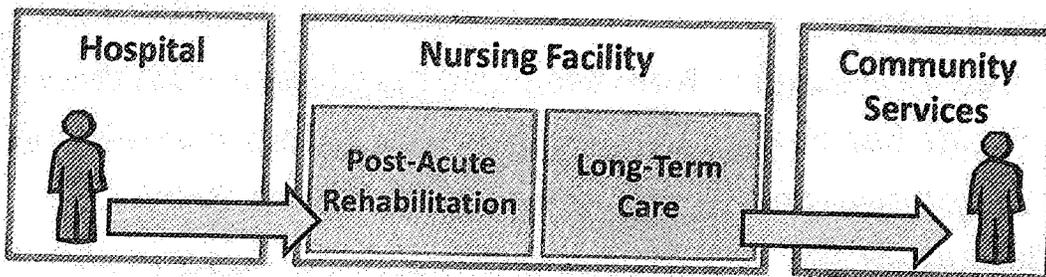
Jobs Budget

- Convert from cost-based to price-based reimbursement
- Link nearly 10% of reimbursement to quality outcomes
- Integrate care delivery for Medicare-Medicaid enrollees

Jobs Budget 2.0

- Flat funding with some exceptions
 - Update peer groups (reclassify Stark and Mahoning Counties)
 - Link 5% rate add-on for “critical access” facilities to quality
 - Remove custom wheelchairs from the nursing facility rate
 - Medicaid net cost is \$36 million (\$13 million state) over two years
- Strengthen quality measures for incentive payments
- Terminate special focus facilities and other regulatory changes
- Provide post-acute rehabilitation in nursing facilities

Rebalance Long-Term Care: Framework for Payment Innovation



Provide post-acute rehabilitation in nursing facilities, not hospitals

- \$1,388 per patient day in a Long-Term Acute-Care Hospital (LTACH)
- \$740 per patient day at the highest Medicare rate for "ultra-high rehabilitation services"
- Opportunity to save \$648 per patient day

Assist nursing home residents who want to move back into the community

- Medicaid spends \$102,500 per year in a nursing home for residents under age 60 who are reasonably physically healthy but have mental illness
- Moving these individuals to a community setting saves \$35,250 per year*



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Health Transformation

*Savings estimate is based on an analysis of 400+ successful HOME Choice placements in 2011.



Rebuild Community Behavioral Health

Jobs Budget

- Free local systems from Medicaid match responsibilities
- Create health homes for people with serious mental illness
- Target investments to restore community capacity

Jobs Budget 2.0

- Leverage Medicaid to rebuild community recovery services
- ***Recovery Requires Community***
 - Allow money to follow 1,200 nursing home residents who want to move back to the community
 - Increase access to safe and affordable housing
 - Prevent inappropriate admissions into nursing homes
- Consolidate Mental Health and Addiction Services (July 2013)

Rebalance Long-Term Care:

Enhance Developmental Disabilities Services

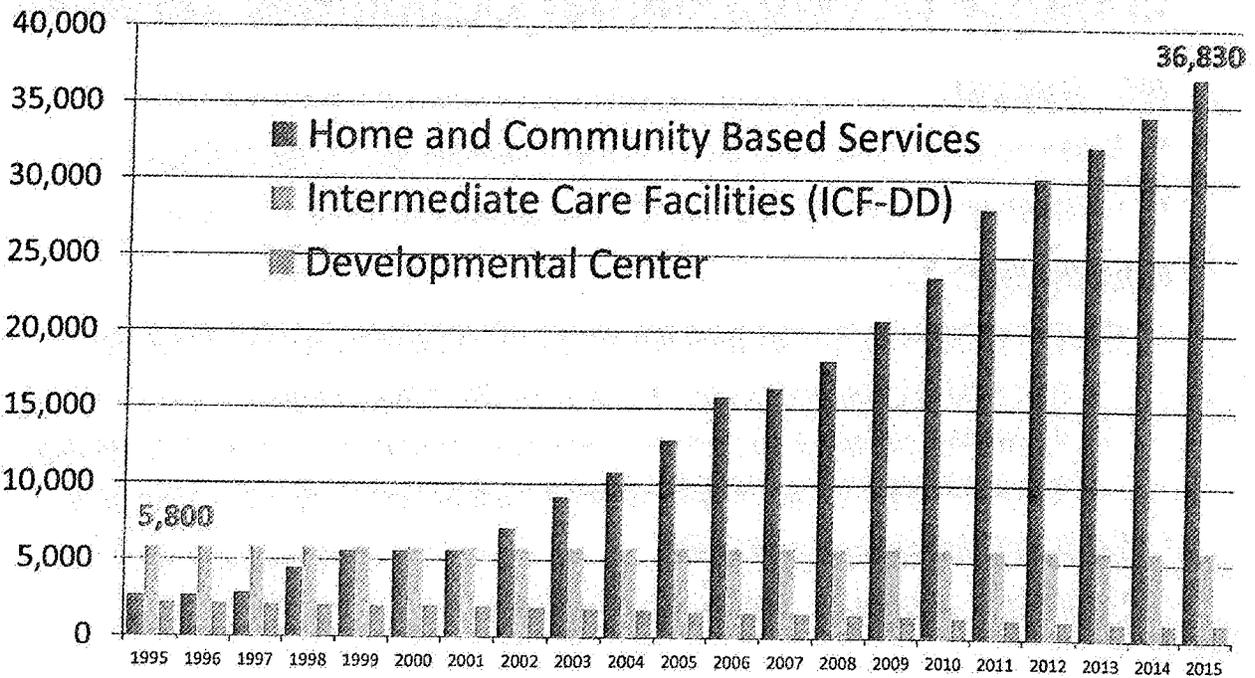
Jobs Budget

- Expanded home and community based services options
- Continued downsizing state-run developmental centers

Jobs Budget 2.0

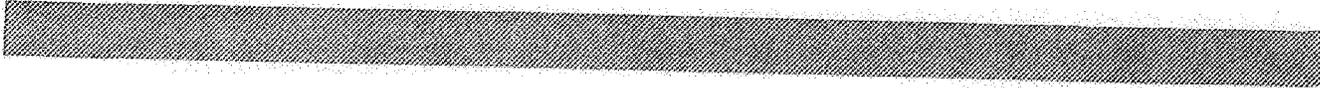
- Convert institutional placements into community settings
 - Flat rate for residents who are less profoundly disabled
 - Financial incentive to convert institutional beds to community services
 - Increase rates for providers serving former residents of institutions
- Support Employment First
- Increase access to autism services

Ohio Department of Developmental Disabilities Residents of Institutions and Recipients of Community Services



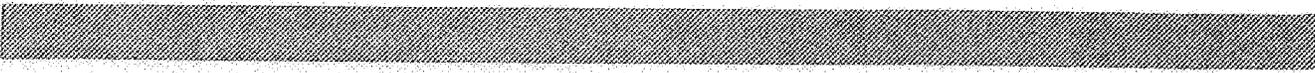
Governor's Office of Health Transformation

SOURCE: Ohio Department of Developmental Disabilities; 1995-2012 actual, 2013-2015 estimated.



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Streamline Health and Human Services:

Organize Government to be More Efficient

Jobs Budget

- Created the Office of Health Transformation
- New Medicaid claims payment system (MITS)
- Reorganized Medicaid programs and budgets

Jobs Budget 2.0

- Consolidate Mental Health and Addiction Services (July 2013)
- Create a unified Medicaid budgeting/accounting system
- Create a Cabinet-Level Department of Medicaid (July 2013)
- Replace Ohio's 34-year-old eligibility system (CRIS-E)
- Coordinate health sector workforce programs



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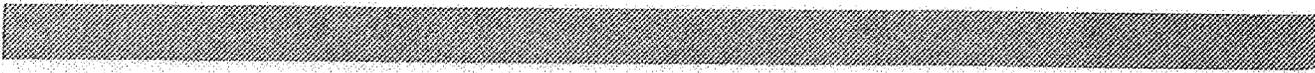
Streamline Health and Human Services:
Implement *Public Health Futures*

Background

- Currently 125 county and city health departments
- 1960, 1993, 2011 reports recommended greater efficiency

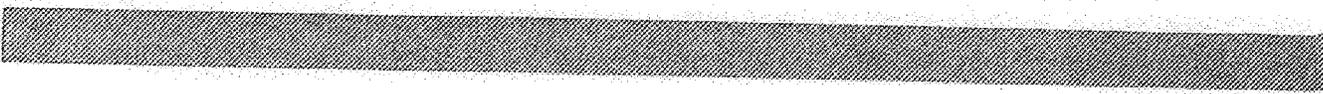
Jobs Budget 2.0

- Consolidate 180 separate grants into 47 regional awards
- Require continuing education for board of health members
- Require sanitarians to be certified by the USFDA
- Share services to improve efficiency
- Require local health departments to be accredited by 2018



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Modernize Medicaid:

Fight Fraud and Abuse

Jobs Budget 2.0

- Conduct more on-site reviews
- Increase audit recoveries
- Better manage hospital utilization
- Involve providers in third-party recoveries
- Revalidate providers every five years
- Track trusts as part of recovery
- Terminate special focus nursing facilities
- Access to Ohio Automated Rx Reporting System (OARRS)
- Saves \$74.3 million (\$27.4 million state) over 2 years



Modernize Medicaid:

Reform Health Plan Payments

Jobs Budget

- Consolidate health plan regions to be more efficient
- Link 1% of health plan payments to performance
- 3rd state approved to integrate care for Medicare-Medicaid

Jobs Budget 2.0

- Reduce administrative overhead 1%, based on economies of scale from expansion/woodwork enrollment
- Give plans more tools to manage drug formularies and reduce the Rx component of the rate 5%
- Cap overall health medical utilization growth at 3% annually
- Withhold up to 2% of payment to earn back through performance
- Saves \$646 million (\$239 million state) over 2 years

Modernize Medicaid: Reform Hospital Payments

- Hospital franchise fee and related payment programs

All funds in millions	FY 2014	FY 2015	FY 2014-15
Hospital Baseline	\$3,999	\$4,235	\$8,235
<i>Franchise fee assessment</i>	<i>(\$524)</i>	<i>(\$524)</i>	<i>(\$1,048)</i>
<i>Upper payment limit</i>	<i>\$502</i>	<i>\$502</i>	<i>1,003</i>
<i>Managed care incentive</i>	<i>\$162</i>	<i>\$162</i>	<i>\$324</i>
<i>5% rate add-on</i>	<i>\$177</i>	<i>\$177</i>	<i>\$353</i>
Franchise fee net impact	\$317	\$317	\$633
Baseline + Franchise Fee Net	\$4,316	\$4,552	\$8,868
<i>Percent Change</i>	<i>7.9%</i>	<i>7.5%</i>	<i>7.7%</i>



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Health Transformation

NOTE: May not sum to total due to rounding.

Modernize Medicaid: Reform Hospital Payments

- Budget savings and cost avoidance

All funds in millions	FY 2014	FY 2015	FY 2014-15
Baseline + Franchise Fee Net	\$4,316	\$4,552	\$8,868
<i>Eliminate 5% rate add-on*</i>	<i>(\$83)</i>	<i>(\$177)</i>	<i>(\$260)</i>
<i>Reduce admissions 25%</i>	<i>(\$34)</i>	<i>(\$69)</i>	<i>(\$103)</i>
<i>Cap capital at 85%*</i>	<i>(\$19)</i>	<i>(\$38)</i>	<i>(\$58)</i>
<i>Non-DRG at 90% of cost</i>	<i>(\$4)</i>	<i>(\$8)</i>	<i>(\$12)</i>
<i>Adjust outpatient fees</i>	<i>(\$22)</i>	<i>(\$44)</i>	<i>(\$67)</i>
<i>Savings and cost avoidance</i>	<i>(\$163)</i>	<i>(\$337)</i>	<i>(\$500)</i>
Estimated Reimbursement	\$4,153	\$4,215	\$8,368
Percent Change	- 3.8%	- 7.4%	- 5.6%

*These cuts are made possible by increased enrollment through woodwork/expansion
May not sum to total due to rounding

Modernize Medicaid: Reform Hospital Payments

- Executive budget overall impact on hospitals

All funds in millions	FY 2014	FY 2015	FY 2014-15
Hospital Baseline	\$3,999	\$4,235	\$8,235
<i>Franchise fee net impact</i>	\$317	\$317	\$633
<i>Savings and cost avoidance</i>	(\$163)	(\$337)	(\$500)
<i>Woodwork now enrolled</i>	\$218	\$408	\$627
<i>Expansion now enrolled</i>	\$211	\$788	\$999
Executive Budget	\$4,582	\$5,411	\$9,993
<i>Dollar change from baseline</i>	\$583	\$1,176	\$1,759
<i>Percent Change</i>	14.6%	27.8%	21.4%



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NOTE: May not sum to total due to rounding.

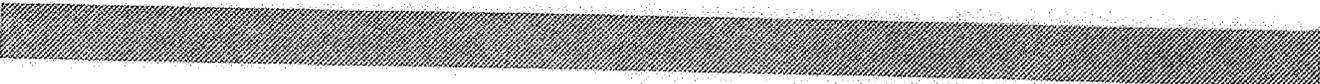


Modernize Medicaid:

Reform Other Provider Payments

Jobs Budget 2.0

- Medicaid payment changes
 - Reduce physician overhead in hospital settings
 - Close payment loopholes for physician services (Holzer Clinic)
 - Reduced rate for multiple radiology procedures
 - Manage utilization of specialty pharmaceuticals
 - Provide drug coverage information through e-prescribing
 - Reimburse only up to the Medicaid maximum rate for all Medicare Part B cost sharing categories except physician services
 - Saves \$165 million (\$61 million state) over two years
- Primary care rate increase
 - Federal requirement that Medicaid pay Medicare rates for two years
 - 82% increase worth \$623 million over two years 100% federally funded



Modernize Medicaid:

Require Greater Personal Responsibility

Jobs Budget 2.0

- New cost sharing requirements above 100% of poverty
- \$8 copayment for using an emergency room for non-emergency conditions
- \$8 copay for non-preferred drugs, \$3 for preferred drugs, and no copay for long-term maintenance drugs (such as insulin)
- Allow a provider to deny a services if the person does not pay the copay, per new proposed federal regulations



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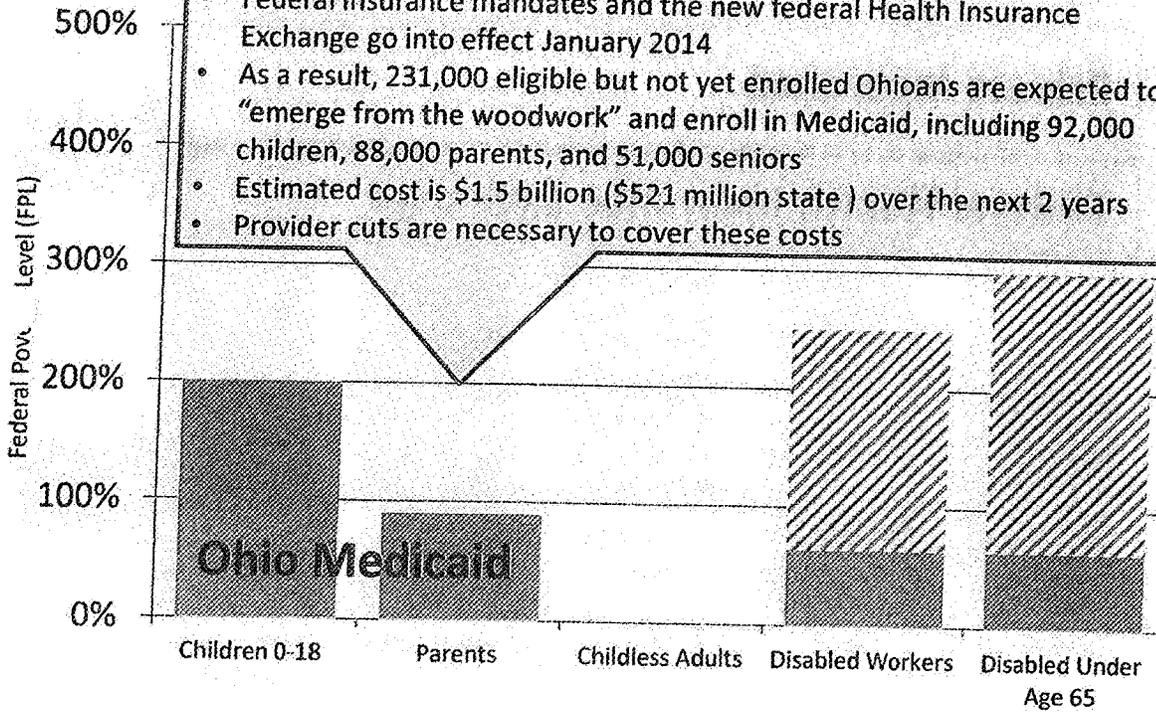


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Woodwork Effect

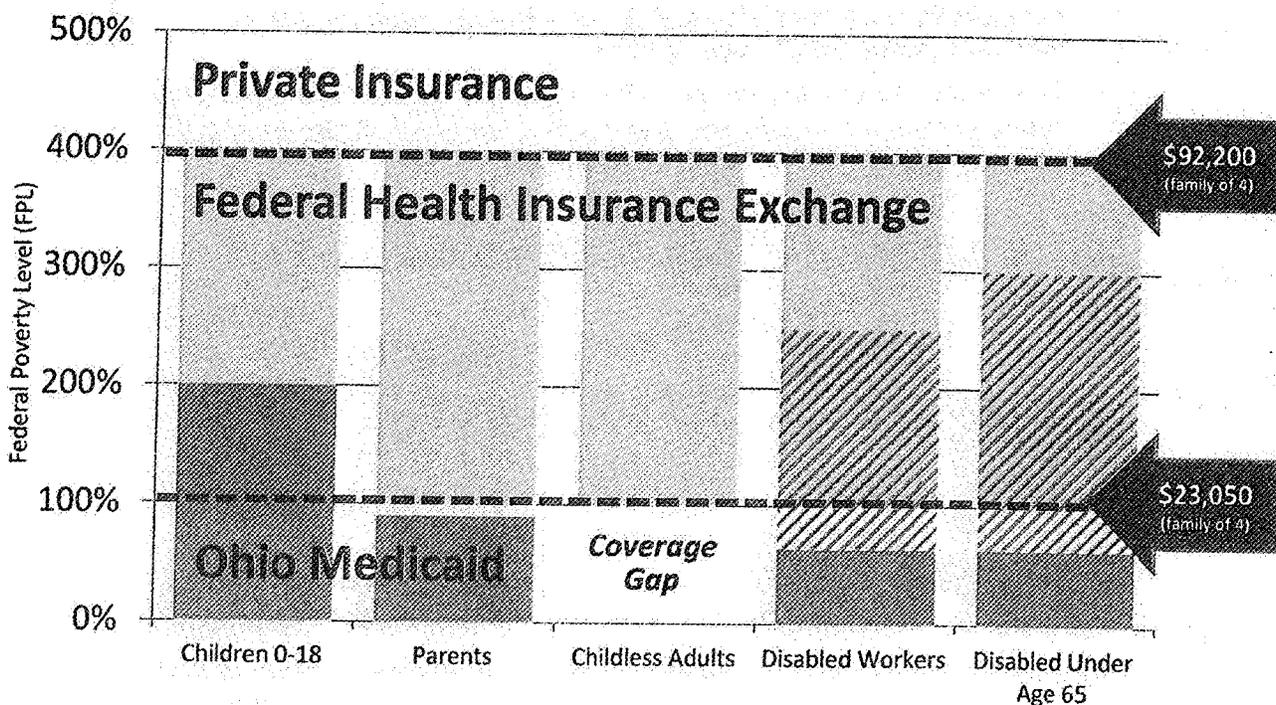
- Federal insurance mandates and the new federal Health Insurance Exchange go into effect January 2014
- As a result, 231,000 eligible but not yet enrolled Ohioans are expected to "emerge from the woodwork" and enroll in Medicaid, including 92,000 children, 88,000 parents, and 51,000 seniors
- Estimated cost is \$1.5 billion (\$521 million state) over the next 2 years
- Provider cuts are necessary to cover these costs



Governor's Office of Health Transformation

SOURCE: Ohio Medicaid; Medicaid eligibility as of February 2013; 2012 poverty level is \$11,170 for an individual and \$23,050 for a family of 4.

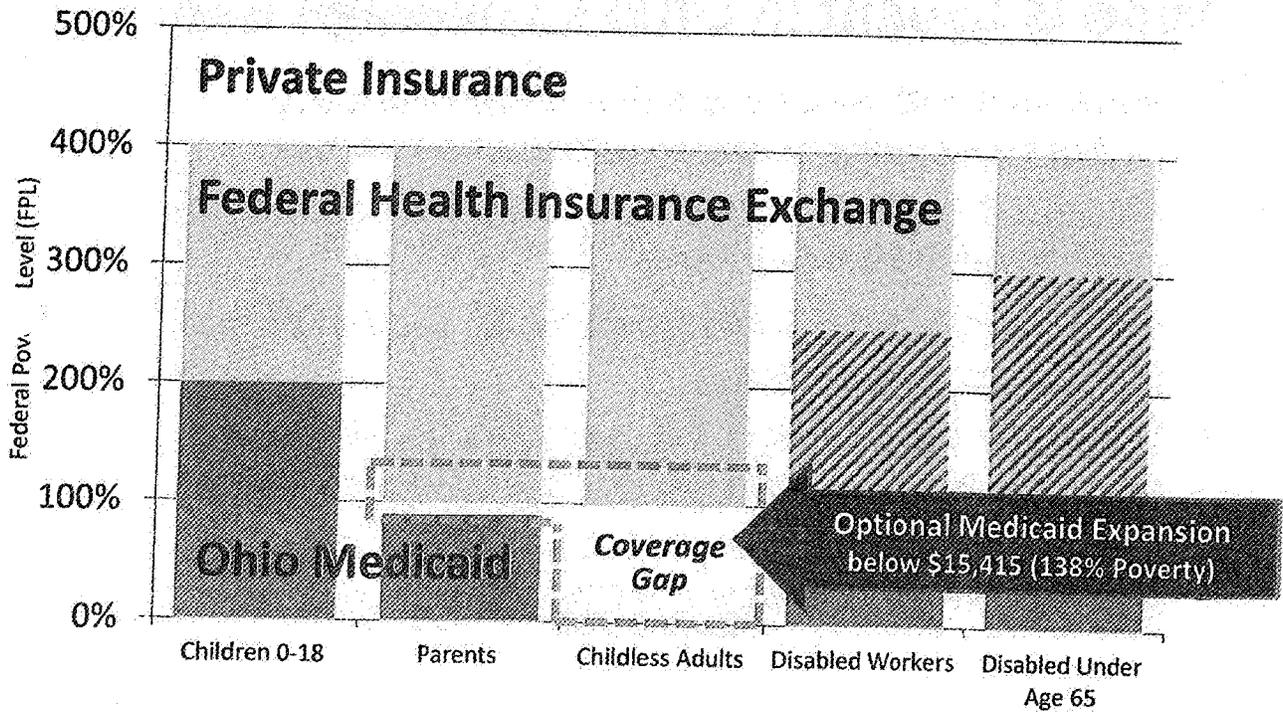
Ohio Medicaid and Insurance Exchange Eligibility in 2014



Governor's Office of Health Transformation

SOURCE: Ohio Medicaid; Medicaid eligibility as of February 2013; Federal Health Insurance Exchange eligibility as of January 2014; 2012 poverty level is \$11,170 for an individual and \$23,050 for a family of 4; over age 65 coverage is through Medicare, not the exchange.

Lowest-Income Ohioans Face a Coverage Gap in 2014



Governor's Office of Health Transformation

SOURCE: Ohio Medicaid; Medicaid eligibility as of February 2013; Federal Health Insurance Exchange eligibility as of January 2014; 2012 poverty level is \$11,170 for an individual and \$23,050 for a family of 4; over age 65 coverage is through Medicare, not the exchange.

Extend Medicaid Coverage:

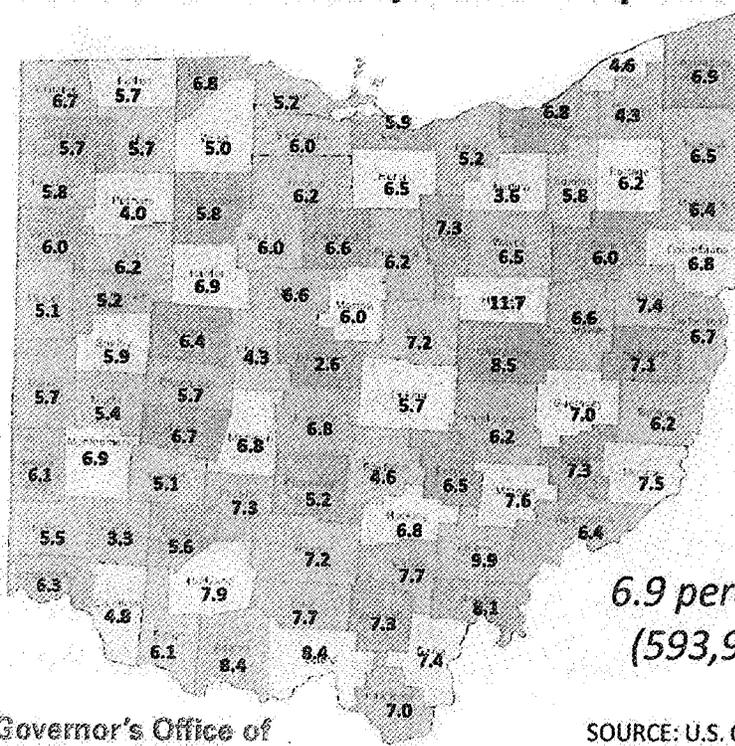
Who Is Caught in Ohio's Coverage Gap?

- Individuals with income less than 138% of poverty
 - \$15,415 for an individual or \$23,050 for a family of four
- About half work, but their employer doesn't offer or they can't afford health insurance
- Many work as health care providers for others but don't themselves have coverage
- Some are unable to work because of mental illness or addiction, but have no regular source of care to recover
- 594,000 Ohioans with annual income below 138% of poverty lack health insurance (6.9% of Ohio's total population)



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Percent of Ohio county residents who were uninsured with income below 138 percent of poverty in 2010



6.9 percent statewide
(593,912 residents)



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SOURCE: U.S. Census, Small Area Health
Insurance Estimates (2010)

Extend Medicaid Coverage: Cover More Low-Income Ohioans

Enrollment Group	Estimated Enrollment Gain/(Loss) as of June 2015
<i>Newly Eligible below 138%</i>	365,616
<i>Previously Eligible above 138%</i>	<u>(90,863)¹</u>
Net New Enrollment at 138%	274,753

1. Individuals who would have been eligible for Medicaid under the current rules even though their income is above 138% of poverty will instead seek coverage on the Health Insurance Exchange, including some parents (10,356) and beneficiaries enrolled through family planning (26,378), transitional Medicaid (54,123), or the Ohio Department of Health Breast and Cervical Cancer Program (6).



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SOURCE: Ohio Medicaid (February 2013)

Extend Medicaid Coverage: Put Ohio's Federal Taxes to Work in Ohio

Federal Funds Impact (in millions)	FY 2014	FY 2015	FY 2014-15
Newly eligible populations (100% federal*)	\$562	\$2,000	\$2,561
Previously eligible population (64% federal)	<u>(\$39)</u>	<u>(\$116)</u>	<u>(\$155)</u>
TOTAL FEDERAL FUNDS INTO OHIO	\$523	\$1,884	\$2,407

*

Calendar Year	Federal Match for Newly Eligible Populations
2014, 2015, 2016	100%
2017	95%
2018	94%
2019	93%
2020+	90%



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SOURCE: Ohio Medicaid (February 2013); may not sum to total due to rounding

Extend Medicaid Coverage: Give Ohio Taxpayers Relief in This Budget

GRF State Share Impact (in millions)	FY 2014	FY 2015	FY 2014-15
Newly eligible enrollees state cost	--	--	--
Previously eligible enrollees state cost	(\$23)	(\$68)	(\$91)
Prison costs that shift to Medicaid	(\$9)	(\$18)	(\$27)
Eliminate hospital 5% rate add-on*	(\$31)	(\$65)	(\$96)
Reduce hospital capital payments*	(\$7)	(\$14)	(\$21)
Health plan administrative savings*	(\$25)	(\$27)	(\$52)
Sales and HIC tax revenue offsets	(\$18)	(\$97)	(\$117)
TOTAL STATE BENEFIT	\$114	\$290	\$404

* These cuts are made possible by increased enrollment through woodwork/expansion and represent GRF state share only (all funds include \$220 million in SFY 2014 and \$470 million in SFY 2015, or \$690 million over two years).



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SOURCE: Ohio Medicaid (February 2013)

Extend Medicaid Coverage: and Future
Give Ohio Taxpayers Relief in This Budgets

GRF State Share Impact (in millions)			FY 2020
Newly eligible enrollees state cost			\$230
Previously eligible enrollees state cost			(\$84)
Prison costs that shift to Medicaid			(\$18)
Eliminate hospital 5% rate add-on			--
Reduce hospital capital payments			--
Health plan administrative savings			--
Sales and HIC tax revenue offsets			<u>(\$165)</u>
TOTAL STATE BENEFIT			\$37



Governor's Office of Health Transformation

SOURCE: Ohio Medicaid (February 2013)

**Extend Medicaid Coverage:
Free Up Local Funds to Meet Local Needs**

Local Funds Impact (in millions)	FY 2014	FY 2015	FY 2014-15
Sales tax revenue	\$4	\$21	\$25
Behavioral health services to Medicaid	<u>\$35</u>	<u>\$70</u>	<u>\$105</u>
TOTAL LOCAL BENEFIT	\$39	\$91	\$130



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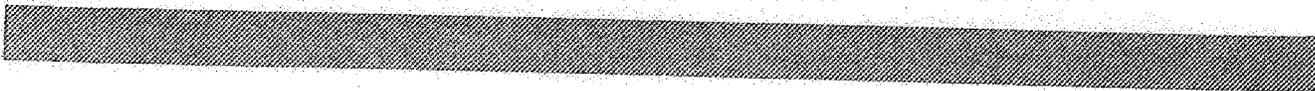
SOURCE: Ohio Medicaid (February 2013)



Extend Medicaid Coverage:

Improve Health Outcomes

- Extend life and reduce health disparities – expansion states reduced mortality and improved outcomes, particularly among older adults, non-whites, and residents of poorer counties
- Improve health outcomes for children – children are 3 times more likely to be uninsured if their parents are uninsured
- Help children make a healthy transition to adulthood – young adults are dropped from Medicaid on their 19th birthday
- Restore community mental health capacity – free up at least \$70 million annually in local behavioral health funding
- Improve care through better coordination – extend Ohio's nationally-recognized Medicaid reforms to more Ohioans



Extend Medicaid Coverage:

Mitigate the Harmful Effects of Obamacare

- Keep the doors open to Ohio's hospitals – federal payments for uncompensated care shrink as a result of Obamacare
- Hold the line on health insurance premium increases – prevent an uncompensated care cost-shift to private-sector premiums
- Protect Ohio taxpayers from federal decisions – codify an automatic opt-out if the federal government changes the rules
- Protect Ohio employers from Obamacare penalties – avoid employees triggering employer penalties on the Exchange

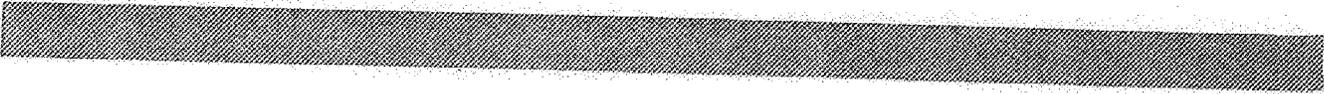
Extend Medicaid Coverage:

Protect Ohio Jobs

- Put Ohio's federal taxes to work in Ohio – \$13 billion over seven years, including \$6 billion into hospitals and \$2 billion into doctors' offices
- Bring new jobs into Ohio – health plans are required to locate staff in Ohio and already have created 1,000 new jobs
- Keep working Ohioans in jobs – most uninsured Ohioans work and connecting them to coverage means keeping them in jobs, including many who provide health care services to others
- Jobs trump politics – Obamacare is not the path Ohio would have chosen, but it is the path the country is on; don't make a bad situation worse by sending Ohio's money to other states



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Modernize Medicaid:

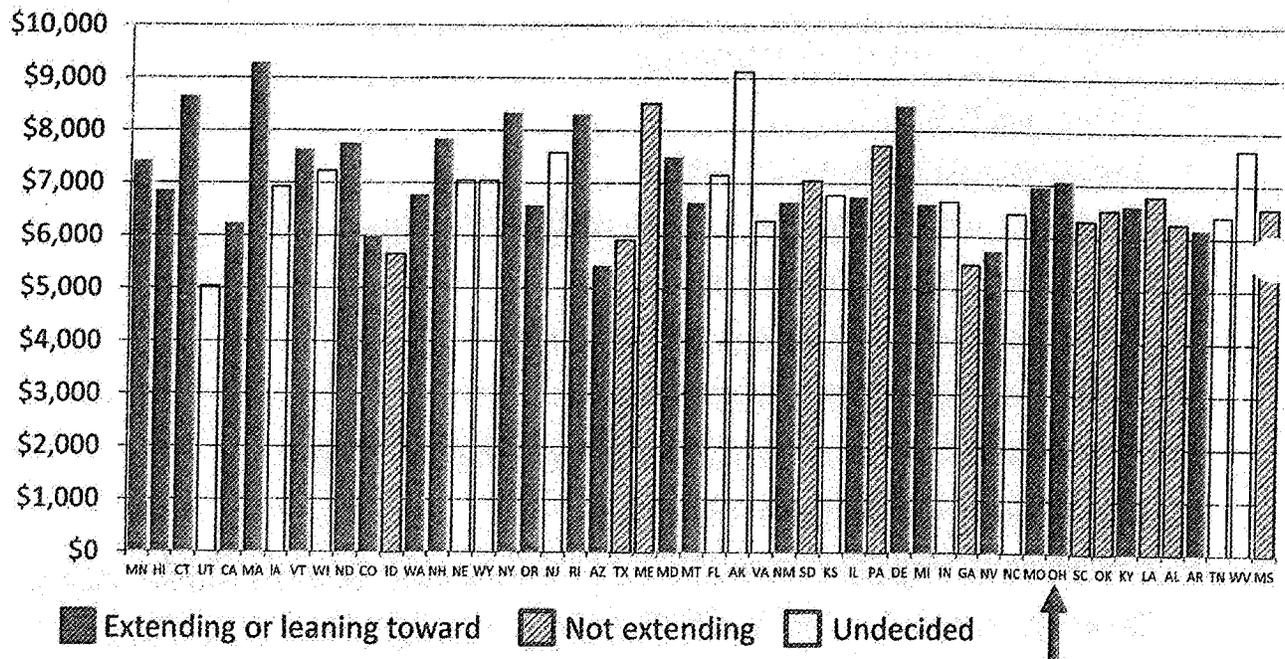
Who Supports Extending Medicaid?

- Ohio Chamber of Commerce
- Ohio Right to Life
- Catholic Conference of Ohio
- County Commissioner's Association of Ohio
- Ohio Hospital Association
- Ohio Children's Hospital Association
- Ohio Association of Health Plans
- National Alliance on Mental Health (NAMI Ohio)
- Ohio State Medical Association
- Columbus Dispatch, Cleveland Plain Dealer, Toledo Blade, Akron Beacon Journal, Cincinnati Enquirer, Youngstown Vindicator

Complete List: www.healthtransformation.ohio.gov/Budget/ExtendMedicaidServices.aspx

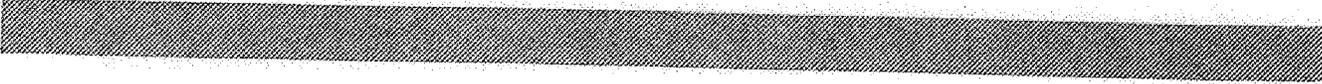
States Proposing to Extend Coverage

(spending per capita by state, in order of resident health outcomes)



Governor's Office of Health Transformation

Sources: CMS *Health Expenditures by State* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (October 2009); The Advisory Board Company, *Where Each State Stands on Medicaid expansion* (2/6/2013).



Extend Medicaid Coverage:

Consequences of Not Extending Coverage

Over the next two years, Ohio taxpayers would need to pay an additional \$404 million in state general revenue (\$690 million all funds) to:

- NOT extend coverage to 275,000 more low-income Ohioans
- NOT keep \$2.4 billion in Ohioans' federal tax dollars in Ohio (\$13 billion over seven years)
- NOT strengthen local mental health and addiction services
- NOT free up \$130 million in local funds to meet local needs
- NOT protect local hospitals from federal cuts



Governor's Office of
Health Transformation

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Jobs Budget 2.0: Ohio Medicaid Spending (All Funds)

All Funds in millions	FY 2013	%	FY 2014	%	FY 2015	%	FY 2014-2015
INITIAL TREND	\$19,666 ²	6.7%	\$20,723	5.4%	\$21,477	3.6%	\$42,200
<i>HB 153 Initiatives¹</i>	\$25		\$822		\$667		\$1,490
<i>Woodwork</i>	--		\$531		\$996		\$1,527
<i>Physician Fee Increase</i>	\$77		\$321		\$262		\$583
BASELINE TOTAL	\$19,768	7.2%	\$22,397	13.3%	\$23,402	4.5%	\$45,799
<i>Savings and Cost Avoidance</i>	--		(\$517)		(\$801)		(\$1,318)
<i>Newly Eligible Enrollment</i>	--		\$500		\$1,927		\$2,426
EXECUTIVE BUDGET	\$19,768	7.2%	\$22,380	13.2%	\$24,528	9.6%	\$46,907

NOTE: May not sum to total due to rounding.



- (1) Integrated Care Delivery for Medicare-Medicaid, health homes for mental illness, disabled children into health plans, Balancing Incentive Program
- (2) SFY 2013 amount adjusted from \$19.8 billion to include the budget for Medicare Part D and UPL Appropriations

Jobs Budget 2.0:

Overall Budget Impact (State Share GRF)

GRF State in millions	FY 2013	%	FY 2014	%	FY 2015	%	FY 2014-2015
INITIAL TREND	\$5,081	2.9%	\$5,520	8.6%	\$5,733	3.9%	\$11,253
<i>HB 153 Initiatives¹</i>	<i>(\$3)</i>		<i>\$136</i>		<i>\$76</i>		<i>\$212</i>
<i>Woodwork</i>	--		<i>\$186</i>		<i>\$335</i>		<i>\$521</i>
<i>Physician Fee Increase</i>	--		--		--		--
BASELINE TOTAL	\$5,079	2.9%	\$5,842	15.0%	\$6,144	5.2%	\$11,986
<i>Savings and Cost Avoidance</i>	--		<i>(\$191)</i>		<i>(\$296)</i>		<i>(\$487)</i>
<i>Newly Eligible Enrollment</i>	--		<i>(\$23)</i>		<i>(\$68)</i>		<i>(\$91)</i>
EXECUTIVE BUDGET	\$5,079	2.9%	\$5,629	10.8%	\$5,779	2.7%	\$11,408



Governor's Office of
Health Transformation

(1) Integrated Care Delivery for Medicare-Medicaid, health homes for mental illness, disabled children into health plans, Balancing Incentive Program

Estimated New Medicaid Enrollment

Enrollment Group	Estimated Enrollment Gain/(Loss) as of June 2015
<i>Newly Eligible below 138%</i>	365,616
<i>Previously Eligible above 138%</i>	<u>(90,863)¹</u>
Net New Enrollment at 138%	274,753
Currently Eligible not enrolled (Woodwork)	<u>230,792²</u>
TOTAL NEW ENROLLMENT	505,545

1. Individuals who would have been eligible for Medicaid under the current rules even though their income is above 138% of poverty will instead seek coverage on the Health Insurance Exchange, including some parents (10,356) and beneficiaries enrolled through family planning (26,378), transitional Medicaid (54,123), or the Ohio Department of Health Breast and Cervical Cancer Program.
2. As a result of federal insurance mandates and the new Federal Health Insurance Exchange going into effect in January 2014, and estimated 231,000 eligible but not yet enrolled Ohioans are expected to "emerge from the woodwork" and enroll in Medicaid, including 92,000 children, 88,000 parents, and 51,000 seniors.



Governor's Office of
Health Transformation

SOURCE: Ohio Medicaid (February 2013)

Today's Topics

- Challenges we face in Ohio
- Health Transformation Priorities
 - Rebalance Long-Term Care
 - Streamline Health and Human Services
 - Modernize Medicaid
 - Extend Medicaid Coverage
 - Overall Budget Impact
- Questions

Coverage Saves Jobs

Ohio's Medicaid reforms in the past two years have been recognized nationally for helping to reduce costs, improve health outcomes, and improve care coordination. Prior to these reforms, Ohio would have been unprepared to efficiently extend Medicaid coverage. Today, however, more Ohioans can be brought into a program that provides higher quality care and better value for the taxpayers who pay for it. The many benefits of extending Medicaid coverage are described below.

Protect Ohio Jobs

- **Keep working Ohioans in jobs.** Most uninsured Ohioans (75 percent) work,¹ but they “live sicker and die younger” than workers with insurance, and they often delay seeking treatment until their health has significantly deteriorated, leading to much higher health care costs.² In contrast, workers with health coverage are far more likely to receive care on a routine and timely basis and receive care from appropriate providers rather than resorting to higher-cost emergency room visits. Ohio Medicaid estimates 275,000 uninsured Ohioans would gain coverage from a Medicaid expansion.³ For the majority who work, connecting them to coverage means keeping them in jobs.
- **Put Ohio's federal taxes to work in Ohio.** Extending Medicaid coverage will convert otherwise uncompensated care into an estimated \$13 billion in new federal spending over the next seven years – that's \$5.9 billion into Ohio's hospitals, \$2.0 billion into doctors' offices, and \$1.4 billion to dentists and other health care providers to support the jobs needed to provide care.⁴ Saying “no” to this plan would not save these federal dollars from being spent or direct them to deficit reduction – it would simply pass them to states that expand, supporting jobs in those states with Ohio's federal tax dollars.
- **Bring new jobs into Ohio.** Most newly eligible Medicaid enrollees will be enrolled in private sector health plans. Medicaid health plans already have created 1,000 new jobs in Ohio as a result of Kasich Administration policies that require plans to headquarter staff in Ohio.⁵ Also, employers look closely at the cost of health care in deciding where to locate their businesses. States that adopt the Medicaid expansion will have a competitive advantage, because employers will not need to underwrite the cost of uncompensated care and all potential workers will have access to a source of coverage.
- **Create a ladder up and out of public assistance.** In addition to aggressive Medicaid reforms already enacted, the Kasich Administration has proposed additional changes to increase personal responsibility and incentives to work. For example, setting co-pays at the maximum allowed by law with the fewest number of exceptions, connecting enrollees to existing employment programs, locking drug abusers into a single doctor or pharmacy, and converting Ohio veterans on Medicaid to the federal benefits they earned. Medicaid is a temporary need for most Ohioans – and should be temporary for *everyone* able to work.

Improve Health Outcomes

- **Extend life and reduce health disparities.** The *New England Journal of Medicine* reported that the three states that expanded Medicaid coverage since 2000 reduced mortality 6.1 percent compared to non-expansion states, with the greatest reductions among older adults, non-whites, and residents of poorer counties. Extending Medicaid coverage decreased uninsured rates by 15 percent, decreased rates of delayed care because of costs by 21 percent, and increased rates of self-reported health status of “excellent” or “very good” by 3.4 percent.⁶ A study published in May 2013 showed that Medicaid reduces rates of depression by 30 percent and virtually eliminates catastrophic medical expenses.⁷
- **Provide coverage to Ohio veterans.** Only 37 percent of the country’s veterans receive health coverage through the Veterans Administration, and almost 90,000 veterans and members of veterans’ families are uninsured in Ohio. Veterans without health coverage often have medical conditions that go untreated, with one in three reporting at least one chronic health condition and roughly one-third of uninsured veterans reporting that they have delayed needed health care because of cost. Under the Governor’s plan, 26,000 uninsured veterans in Ohio and an additional 12,000 spouses and family members would qualify for health coverage,⁸ improving the health and quality of life for thousands of Ohioans who were willing to put their lives at risk for their country.
- **Improve health outcomes for Ohio children.** Covering parents not only improves their own lives but also the lives of their children. The Institute of Medicine reports that the financial stability of a whole family can be put at risk if only one person is uninsured and needs treatment for unexpected health care costs.⁹ Children are three times more likely to be eligible for coverage but uninsured if their parents are uninsured. An estimated 176,000 uninsured parents will be covered under a Medicaid expansion.¹⁰ Covering these parents makes it more likely that their children will receive needed care.
- **Help children make a healthy transition to adulthood.** Currently, young adults become ineligible for Medicaid on their 19th birthday (21 for foster children) and many of them, after having a regular source of coverage through Medicaid, become uninsured. Extending Medicaid coverage provides continuity of care for these individuals, some of whom have mental illness or addiction disorders that would worsen without access to prescription drugs and other treatment services that are covered by Medicaid.
- **Restore community mental health capacity.** Most Ohioans who receive services from county boards of mental health and addiction services will become eligible for Medicaid under an expansion. Extending Medicaid coverage will free up an estimated \$70 million annually statewide in county levy dollars that could be spent on other priorities, like employment services. It will also improve Ohio’s criminal justice system and promote safer communities because more people will be receiving necessary mental health services, and fewer people will be cycling in and out of the criminal justice system.¹¹

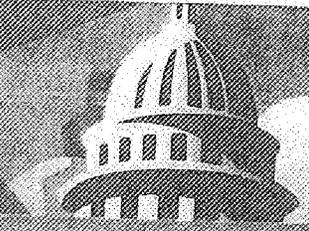
Mitigate the Harmful Consequences of Obamacare

- **Jobs trump politics.** Governor Kasich opposes President Obama's health care plan. That's why Ohio opted not to run a federally mandated Health Insurance Exchange and why Ohio joined a coalition of states that tried to block the program in court. But the law was upheld by the Supreme Court and the President was re-elected. No matter what Ohio decides on Medicaid, health insurance premiums are going up as a result of Obamacare. But it will make a bad situation far worse if Ohio does not extend Medicaid coverage and reclaim its share of federal taxes to support jobs here in Ohio – jobs that will be created in other states with our money if Ohio does not extend coverage.
- **Keep the doors open to Ohio's hospitals.** When low-income Ohioans without health insurance need health care, they often go to the emergency room because hospitals are required to provide care even if the individual doesn't have the ability to pay. This unpaid care cost hospitals more than \$1.2 billion in 2012. Some of those costs (\$356 million in 2012¹²) are paid for by the federal "disproportionate share hospital" (DSH) program. But Obamacare cuts DSH subsidies beginning in 2014, forcing hospitals to absorb those costs or shift them to businesses and families with insurance. Extending Medicaid coverage will help ensure that hospitals receive payment for the services they provide, protect rural and safety net hospitals from being pushed to the brink, protect hospitals' credit,¹³ and further limit the uncompensated costs that shift to employers and privately insured families.
- **Protect Ohio employers from Obamacare penalties.** Despite a one year delay, Ohio employers eventually will be subject to up to \$88 million per year in Obamacare penalties if Ohio does not expand Medicaid.¹⁴ Under federal reform, employers with 50 or more workers are subject to penalties if any full-time employees receive a premium subsidy through the Health Insurance Exchange. Employees are eligible for premium subsidies only if they do not have access to Medicaid and their employer does not offer coverage that meets minimum requirements. In states that do not extend coverage, low-income workers who otherwise might have enrolled in Medicaid may instead access premium subsidies, thereby putting their employer at risk of penalties.¹⁵
- **Protect Ohio taxpayers from federal decisions.** The Heritage Foundation warns that taxpayers need to be protected from the federal government shifting expansion costs to states.¹⁶ Governor Kasich agrees and, despite federal assurances that states may opt in and out of covering newly eligible populations at any time,¹⁷ recommends an automatic opt-out trigger so that if for any reason the federal government reduces its financial participation, then the program for newly eligible populations shuts down, and Ohio taxpayers are not stuck holding the bill.

NOTES

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- ¹ U.S. Census, *Distribution of the nonelderly uninsured by family work status (2010-2011)*.
- ² Institute of Medicine, *America's Uninsured Crisis: Consequences for Health and Health Care (2009)*.
- ³ Estimate includes uninsured newly eligible populations only, not woodwork; an additional 230,800 currently eligible but not enrolled children, parents and seniors who are uninsured are also expected to enroll.
- ⁴ Estimate includes federal funds for newly eligible populations only, not woodwork. The distribution among providers is based on the current distribution of spending among providers in Medicaid managed care: 45 percent hospital, 16 percent physician, 18 percent drug, and 11 percent other.
- ⁵ Business First, *Managed care companies adding 1,000 jobs with Medicaid shift (January 11, 2013)*.
- ⁶ NEJM, *Mortality and access to care after state Medicaid expansions (July 25, 2012)*.
- ⁷ NEJM, *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes (May 2013)*.
- ⁸ Robert Wood Johnson Foundation, *Uninsured Veterans and Family Members: State and National Estimates of Expanded Medicaid Eligibility Under the ACA (March 2013)*.
- ⁹ Institute of Medicine, *America's Uninsured Crisis: Consequences for Health and Health Care (2009)*.
- ¹⁰ Estimate includes 59,000 newly eligible and 117,000 currently eligible but uninsured parents.
- ¹¹ See also, *The Waterfall Effect: Transformative impacts of Medicaid expansion on states (January 2013)*.
- ¹² In 2012, Ohio hospitals paid \$199 million in Hospital Care Assurance Program assessments used to draw federal DSH payments of \$555 million, resulting in a \$356 million net payment to Ohio's hospitals.
- ¹³ Moody's Investor Services, *Medicaid and Medicare DSH payment reductions could challenge states and hospitals (March 2013)*.
- ¹⁴ Jackson Hewitt, *The Supreme Court's ACA Decision and its Hidden Surprise for Employers (March 2013)*.
- ¹⁵ American Academy of Actuaries, *Implications of Medicaid Expansion Decisions on Private Coverage (2012)*.
- ¹⁶ The Heritage Foundation, *Medicaid Expansion Will Become More Costly to States (August 2012)*.
- ¹⁷ CMS, *Frequently asked questions on exchanges, market reforms and Medicaid (December 2012)*.

AMERICAN ACADEMY OF ACTUARIES
DECISION BRIEF



Key Points

The Affordable Care Act includes a provision to expand Medicaid eligibility. The recent Supreme Court decision, however, gives states the option of implementing the Medicaid expansion. Whether and to what extent states choose to expand Medicaid can have implications for private coverage. State and federal policymakers and regulators should consider several issues as they are making their Medicaid expansion decisions:

- Individual market premiums could increase in states that opt out of the Medicaid expansion, due to health status differences of new enrollees.
- Exchange premiums also may increase due to spreading fixed reinsurance subsidies over a larger enrollee population.
- Basic Health Program decisions by states, pending clarifications from HHS, can affect the risk profile of enrollees in an exchange.
- Employers may be at greater risk of penalties in states that don't expand Medicaid eligibility.

**Implications of Medicaid Expansion
Decisions on Private Coverage**

The Affordable Care Act (ACA) includes a provision to expand Medicaid eligibility to 133 percent of the federal poverty level (FPL). This would effectively expand Medicaid eligibility to 138 percent of the FPL because Medicaid eligibility determinations would disregard 5 percent of income. The recent Supreme Court decision, however, gives states the option of whether to implement the Medicaid expansion. U.S. Department of Health and Human Services officials have subsequently indicated that states will have the flexibility of whether and when to implement the expansion, and that states choosing to implement the expansion can decide later to roll it back. In addition, although states will have the flexibility to implement partial Medicaid expansions, enhanced funding would be available only for states that implement the full expansion.

Whether and to what extent states expand Medicaid eligibility will affect not only access to coverage and costs to the federal government and the states, but also the premiums for private insurance coverage. This decision brief highlights some of the issues that federal and state policymakers and regulators should consider as they are making their Medicaid expansion decisions.

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Individual market premiums could increase in states that opt out of the Medicaid expansion, due to health status differences of new enrollees.

The ACA provides for premium subsidies to individuals purchasing coverage in an Affordable Insurance Exchange if they have income between 100 percent and 400 percent of FPL and are neither eligible for Medicaid nor offered employer-sponsored coverage that meets minimum value and affordability requirements. Individuals below 100 percent of FPL who are not eligible for Medicaid are not eligible for subsidies in an exchange. If a state opts not to extend Medicaid eligibility to 138 percent of FPL, then individuals 100 percent to 138 percent of FPL who otherwise would have been eligible for Medicaid will have access to premium subsidies. This population can be expected to have higher health care needs than higher-income exchange enrollees. The Congressional Budget Office (CBO) estimates that due to the likely higher health spending among lower-income enrollees, average individual market premiums will be 2 percent higher than projections made under the assumption that all states expand Medicaid to 138 percent of FPL.^{1,2} Note that this estimate reflects the increase in average premiums overall, including not only states that opt out of the Medicaid expansion but also those that do expand Medicaid. Therefore, premium increases would be even higher among those

states that do not expand Medicaid.³ Premium increases would be borne by nonsubsidized purchasers and by the federal government for subsidized enrollees.

Exchange premiums also may increase due to spreading fixed reinsurance subsidies over a larger enrollee population.

The CBO estimate reflects premium increases due only to expected higher health spending among lower-income enrollees. Premiums also would be higher during the initial years of implementation due to lower per-enrollee reinsurance subsidies. The temporary reinsurance program for years 2014-2016, designed to stabilize premiums for coverage in the individual market, provides payments to individual market plans for their high-cost enrollees. Because the funding for the reinsurance program is fixed, an influx of additional individual market enrollees would mean that a lower payment would be available on a per-enrollee basis.⁴ The reduction in the reinsurance subsidy as a percent of the premium could exceed that due solely to higher enrollment if, as discussed above, average premiums increase due to the greater health costs of new enrollees. Clarification is needed on whether and how the reinsurance subsidy amount will be allocated across states based on their Medicaid expansion decisions. The offsetting impact of lower reinsurance fees per insured life, which are levied not only on individual market plans

¹Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision." July 2012. Available at: <http://cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>

²Because risk pooling for premium setting purposes includes those purchasing coverage both inside and outside of an exchange, participation of a higher-cost population in the exchange also will affect premiums for plans purchased outside of the exchange.

³In addition to any premium effects, states also may need to consider recalibrating the risk adjustment methodology to reflect the private enrollee population resulting from its Medicaid expansion decision.

⁴Take-up rates greater than expected, even without an influx of individuals who otherwise would have been eligible for a Medicaid expansion, also would have the effect of lowering the per-enrollee reinsurance subsidy, thereby increasing the premium.

Under the direction of Mita Lodh, FSA, MAAA, PhD and Cori E. Uccello, FSA, MAAA, FCA, MPP, this decision brief was drafted by a work group of the Academy's Health Practice Council.

but also on group plans, would likely be small in comparison.

Basic Health Program decisions by states, pending clarifications from HHS, can affect the risk profile of enrollees in an exchange.

The ACA gives states the option of using federal subsidies toward a state Basic Health Program (BHP) for individuals 133 percent to 200 percent of FPL who neither are eligible for Medicaid nor offered employer-sponsored coverage that meets minimum value and affordability requirements.⁵ The BHP must cover at least the essential health benefits that exchange plans must cover. In addition, BHP enrollee premiums cannot exceed those in the exchange and cost sharing is limited, based on income. The federal subsidy that states could use toward the BHP would be 95 percent of the premium and cost-sharing subsidies that would be available in an exchange.

If states that expand Medicaid to 138 percent of FPL develop a BHP for the 138 percent to 200 percent of FPL population through contracts with private plans or providers at discounted rates compared with private plans in the exchange, then the BHP potentially could offer richer benefits at a lower cost than plans in the exchange. The BHP could reduce the number of participants who need to transition between Medicaid coverage and subsidized private plan coverage in an exchange.

For states not expanding Medicaid eligibility to 138 percent of FPL, federal clarification is needed in several areas, including:

- Whether federal exchange subsidies would be available for states to use toward the BHP for the 100 percent to 133 percent of FPL population (the ACA does not appear to allow this);
- Even if federal exchange subsidies would not be available for the BHP, whether states

would be allowed to cover at their own cost the 100 percent to 133 percent of FPL population; and

- Whether non-expansion states would be prohibited from implementing a 133 percent to 200 percent of FPL BHP altogether.

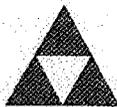
If non-expansion states are allowed to develop a BHP to cover those at 133 percent to 200 percent of FPL, but not those at 100 percent to 133 percent of FPL, a discontinuity in coverage would occur. Individuals at 100 percent to 133 percent of FPL would be covered in an exchange, individuals at 133 percent to 200 percent of FPL would be covered by the BHP, and individuals at 200+ percent of FPL would be covered in an exchange.

Federal guidance will influence state decisions on BHPs which, in turn, will affect enrollee risk profiles and premium levels in an exchange.

Employers may be at greater risk of penalties in states that don't expand Medicaid eligibility.

Under the ACA, employers with 50 or more workers are subject to penalties if any full-time employees receive a premium subsidy for coverage in the exchange. Employees are eligible for premium subsidies only if they don't have access to Medicaid and their employer does not offer coverage that meets minimum value requirements and is deemed to be affordable to the employees (i.e., less than 9.5 percent of income). In states that opt out of the Medicaid expansion, low-income workers who otherwise might have enrolled in Medicaid might access premium subsidies thereby putting the employer at risk of penalties.

⁵Unlike eligibility for the Medicaid expansion, which reflects a 5 percent income disregard, eligibility for the BHP does not include a 5 percent income disregard. Thus, while the full Medicaid expansion extends eligibility to 138 percent of FPL, BHP eligibility begins at 133 percent of FPL.



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Announcement: Moody's: Medicaid and Medicare DSH payment reductions could challenge states and hospitals

Global Credit Research - 14 Mar 2013

New York, March 14, 2013 – The upcoming reductions called for in the Affordable Care Act to federal disproportionate share hospital (DSH) payments, estimated to rise to \$17 billion annually by 2019, will lead to political and budgetary pressure on state governments as they seek to replace the lost funds says Moody's Investors Service. Hospitals providing high levels of charity care and with heavy Medicaid loads will be most vulnerable to budget shortfalls because of the DSH reductions.

Pressures will be greatest in states that opt out of Medicaid expansion, but have a relatively high proportion of uninsured residents, says Moody's in the report "Reduction of Medicaid & Medicare Disproportionate Share Hospital Payments a Looming Challenge for States and Hospitals."

The DSH reductions are expected to be covered by the lower cost of charity care, as the Affordable Care Act is aimed at lowering the ranks of the uninsured. However, states that opt out of the Medicaid expansion, as the June 2012 Supreme Court ruling on the Affordable Care Act allows, may face large uninsured populations at the same time that the DSH payments decline.

"States that opt out of Medicaid expansion will have to choose whether to compensate for the shortfalls with their own funds or leave hospitals to absorb the costs, which will increase rating pressure on the hospitals," says Nicole Johnson, a Moody's Senior Vice President. "States that choose to fund uncompensated care costs themselves could face budgetary strain."

States use federal Medicaid and Medicare DSH funding, to help hospitals with large numbers of Medicaid and low-income uninsured patients provide care.

To date, governors in 14 states have recommended against Medicaid expansion, and the governors of three states are leaning in this direction. Seven of those 14 states already have above average levels of uninsured adults that would qualify for Medicaid under the Affordable Care Act.

At the hospital level, large urban "safety net" hospitals that typically treat large populations of Medicaid and uninsured patients are most at risk from the DSH phase-out, says Moody's.

The increased costs could lead to pressure on some hospital ratings unless they are offset by higher Medicaid and private insurance rates, lower numbers of uninsured patients, or backfill funding from states, says Moody's.

Moody's notes that Medicaid DSH payments are scheduled to be restored in federal fiscal year 2022, but federal budget austerity could alter that, as actions to reduce the federal deficit have already pushed back increased DSH payments once.

For more information, Moody's research subscribers can access this report at http://www.moody's.com/research/Reduction-of-Medicaid-and-Medicare-Disproportionate-Share-Hospital-Payments-a-PBM_PBM150991.

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Summary¹

From 2001 to 2004, the Institute of Medicine (IOM) issued a comprehensive series of six reports that reviewed and reported on the evidence on how children, adults, families, and communities are affected by the lack of health insurance.² The committee reported that the evidence showed that not having health insurance is harmful to the health and overall well-being of both children and adults (Box S-1). In addition, the committee established principles for expanding coverage for all and recommended in the 2004 report *Insuring America's Health* that the President and Congress act by 2010 to achieve universal coverage, noting:

"The benefits of universal coverage would enrich all Americans, whether accounted for in terms of improved health and longer life spans, greater economic productivity, financial security, or the stabilization of communities' health care systems."

It is now 5 years since the IOM made its recommendation, and there has still been no comprehensive national effort to achieve coverage for all Americans. In 2007, 45.7 million people in the United States—17.2 percent of the nonelderly U.S. population—were without health insurance. A severely weakened economy, rising health care and health insurance costs, growing unemployment, and declining employment-based health insurance coverage are all evidence that the U.S. health insurance system is in a state

¹ This summary does not include references. Citations for the findings presented in the summary appear in the subsequent chapters of the full report.

² For copies of the previous IOM report series on the consequences of uninsurance, please visit www.nap.edu.

BOX S-1
Previous IOM Findings on the Consequences
of Uninsurance, 2004

The clinical literature overwhelmingly shows that uninsured people, children as well as adults, suffer worse health and die sooner than those with insurance. Families with even one member who is uninsured lose peace of mind and can become burdened with enormous medical bills. Uninsurance at the community level is associated with financial instability for health care providers and institutions, reduced hospital services and capacity, and significant cuts in public health programs, which may diminish access to certain types of care for all residents, even those who have coverage. The economic vitality of the nation is limited by productivity lost as a result of the poorer health and premature death or disability of uninsured workers.

of crisis. There is no evidence to suggest that the trends driving loss of insurance coverage will reverse without concerted action.

With a new administration and a new Congress in 2009, many citizens, policy makers, and opinion leaders anticipate renewed energy and interest in finding a way to reverse declines in health insurance coverage and, ultimately, to expand coverage to all in the United States. It is in this context that the Robert Wood Johnson Foundation asked the IOM to conduct the present study. In response to the Foundation's request, the IOM appointed the Committee on Health Insurance Status and Its Consequences in April 2008.

The committee's charge was to review and evaluate the research evidence on the health and other consequences of uninsurance that has emerged since the IOM's earlier series of reports that might help inform the health care reform efforts in 2009 (Box S-2). Whereas the previous IOM studies on uninsurance were broad and comprehensive in scope, the present study focuses more narrowly on the following critical 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?

FINDINGS

In executing its charge, the committee has studied the research literature since 2002 and applied rigorous scientific criteria to set the record straight on the issue of health insurance coverage. The committee reports findings in three key areas: (1) trends in health insurance coverage and forces driving

BOX S-2
Charge to the IOM Committee on Health Insurance Status and Its Consequences

The overarching objective of this study is to help inform the health reform policy debate as it unfolds in 2009. The committee will assess the research evidence—that has emerged since the IOM's 2001 to 2004 series of reports on uninsurance—on the consequences of uninsurance. Rather than performing a comprehensive review, the committee is charged with reviewing the literature to identify new insights not yet known or appreciated when the IOM's earlier reports were developed.

The search for new evidence will include the published literature on the consequences of uninsurance for individuals, families, communities, specific population groups, and safety net and other providers. The consequences may be related to health outcomes, such as morbidity and mortality, access to health care services, and economic impacts such as affordability of health coverage and its associated financing burden.

them, (2) the health consequences of uninsurance for children and adults, and (3) the implications of high community-level rates of uninsurance on people with health insurance in those communities. The committee's findings are summarized below.

Caught in a Downward Spiral: Health Insurance Coverage Is Declining and Will Continue to Decline

The fear of being without health insurance coverage is a growing strain on American families' sense of health and well-being. Concerns about losing health insurance coverage are well founded. In 2007, 5.9 million more people were uninsured than when the IOM issued its initial report on uninsurance. The uninsured included 8.1 million children and 36.8 million adults ages 18 to 64. In 2007, nearly 1 in 10 children and 1 in 5 nonelderly adults in the United States were without health insurance.³

Over the last decade, health insurance coverage has declined and will continue to decline. The cost of health care is driving the downward trend in both the private and public sectors. Health care costs and insurance premiums are growing at rates greater than the U.S. economy and family incomes. From 2001 to 2006, U.S. per capita health care spending grew by 47 percent compared to the 34 percent increase in gross domestic prod-

³ The vast majority of the population age 65 and older has health insurance coverage through Medicare or other sources. For that reason, this study focuses on uninsurance among children and nonelderly adults.

uct. This trend shows no signs of abating. According to the Centers for Medicare & Medicaid Services, total U.S. health care spending may nearly double between 2008 and 2017.

The rapid growth in health care costs is making it increasingly difficult for U.S. employers to offer health insurance coverage to their workers. In addition, many employers have replaced permanent, full-time jobs with contract, part-time, and temporary positions that do not come with health benefits. And, early retirees are less likely to be offered retiree health insurance benefits than in the past.

Furthermore, even when employers are able to offer health insurance to their employees, increasing numbers of employees are declining these offers because they cannot afford the premiums. Between 1999 and 2008, the average annual employee premium contribution for family coverage rose from \$1,543 to \$3,354, far outpacing the growth in family incomes. High premium costs are especially burdensome to lower wage workers, who are finding it more and more difficult to take up offers of coverage from their employers.

Individuals without employer-sponsored health insurance who are not eligible for public insurance must rely on a limited nongroup health insurance market to obtain coverage. The premium costs for nongroup coverage can be exceedingly high and individual subscribers must pay the entire cost without a contribution from an employer. In most states, the insurer may deny coverage completely, impose either a permanent or temporary preexisting condition limitation on coverage, or charge a higher premium based on health status, occupation, and other personal characteristics. Some state and federal regulations have been put in place to help promote access to nongroup coverage, but current data limitations frustrate research that might illuminate the impact of the regulations.

It is possible that additional millions of low-income Americans would be uninsured today were it not for recent state and federal efforts to expand coverage. States and the federal government have substantially increased health coverage among low-income children and, to a lesser degree, among adults in the last decade, by expanding eligibility, conducting outreach to people already eligible, and expediting enrollment in Medicaid and State Children's Health Insurance Program (SCHIP) programs. Given the severity of the current economic crisis, however, some states will be unable to sustain these expansions—just at the time that increasing numbers of Americans are losing their jobs, their employer-sponsored health coverage, or both.

The committee's key findings on recent trends in health insurance coverage are summarized in Box S-3. In sum, health insurance coverage in the United States is declining and the situation will get worse. The crisis is

engulfing employer-sponsored insurance, the cornerstone of private health coverage, and also threatens expansions in public coverage.

Coverage Matters: Health Insurance Is Integral to Personal Well-Being and Health⁴

When policy makers and researchers consider potential solutions to the problem 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.

The committee found that the new research evidence on the consequences of health insurance for children and adults is of higher quality and stronger than ever before. This robust body of evidence demonstrates substantial health benefits of health insurance coverage.

Important insights into how children benefit when they acquire health insurance are provided by well-designed evaluations of enrollment in Medicaid and SCHIP programs. With health insurance, it is clear that children gain 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. With health insurance, 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. With health insurance, children have fewer avoidable hospitalizations, improved asthma outcomes, and fewer missed days of school.

For adults, there are serious harms and sometimes grave consequences to being without health insurance. Men and women without insurance are much less likely to receive clinical preventive services that have the potential to reduce unnecessary morbidity and premature death. Chronically ill adults delay or forgo visits with physicians and clinically effective therapies, including prescription medications. Uninsured adults are more likely to be diagnosed with later stage cancers that are detectable by preventive screening or by contact with a clinician who can assess worrisome symptoms. Without health insurance, adults are more likely to die from trauma

⁴ The findings on the health consequences of uninsurance are based on two background papers commissioned by the IOM committee: (1) Health Consequences of Uninsurance Among Adults in the United States: An Update by J. Michael McWilliams, M.D., Ph.D., Harvard Medical School, and (2) Health and Access Consequences of Uninsurance Among Children in the United States: An Update by Genevieve M. Kenney, Ph.D., and Embry Howell, Ph.D., The Urban Institute.

BOX S-3

Key Findings on Trends in Health Insurance Coverage

Health insurance coverage has declined over the last decade despite increases in public program coverage and will continue to decline. There is no evidence to suggest that the trends driving loss of insurance coverage will reverse without concerted action. High and rising health care costs threaten not only employer-sponsored coverage, but also recent expansions in public coverage.

Private Health Insurance

- The rising cost of health care is driving the decline in private health insurance coverage. Health care costs and insurance premiums are growing substantially faster than the economy and family incomes.
- As the costs of health care increase, the importance and value of coverage increases for individuals, while at the same time it becomes less affordable.
- Employment has shifted away from industries with traditionally high rates of coverage to jobs with historically lower rates of coverage. In some industries, employers have relied more heavily on jobs without health benefits, such as part-time and shorter-term employment and contract and temporary jobs.
- Fewer workers, particularly among those with lower wages, are being offered employer-sponsored coverage and fewer among them can afford the premiums. And, early retirees are less likely to be offered retiree health insurance benefits than in the past.

Nongroup Insurance

- For many without employer-sponsored group coverage, nongroup health insurance coverage is prohibitively expensive or unavailable
 - Access to nongroup coverage is highly dependent on individual circumstances and geographic location.
 - People with preexisting health conditions who lose employer-sponsored insurance face significant barriers to coverage, including unaffordable premiums.

Public Health Insurance

- Long-term fiscal pressures on the federal budget threaten to undermine bedrock state and federal health care programs.
- With a severely weakened economy and rising health care costs, some states will not be able to sustain their recent expansions of public programs for low-income children and adults.
- Increases in unemployment will further fuel the decline in the number of people with employer-sponsored coverage and put additional stress on state Medicaid and SCHIP programs.

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or other serious acute conditions, such as heart attacks or strokes. Adults with cancer, cardiovascular disease, serious injury, stroke, respiratory failure, chronic obstructive pulmonary disease or asthma exacerbation, hip fracture, seizures, and serious injury are more likely to suffer poorer health outcomes, greater limitations in quality of life, and premature death if they lack health insurance. New evidence demonstrates that gaining health insurance ameliorates many of these problems.

The committee's key findings on the health consequences of uninsurance are summarized in Box S-4. In sum, despite the availability of some safety net services, there is a chasm between health care needs and access to effective health care services for uninsured children and adults. Health insurance coverage in the United States is integral to individuals' personal well-being and health.

**Communities at Risk: High Levels of Uninsurance in Communities
May Undermine Health Care for the Insured Population**

Many of America's towns and cities have high concentrations of children and adults under age 65 who lack health insurance. Thus, the question arises: What are the implications of high rates of uninsurance for affected communities and for insured people in those communities?⁵

It has been estimated that the annual cost of health services provided to uninsured people in the United States will total about \$86 billion in 2008. Uninsured patients will pay approximately \$30 billion for these services out of pocket and receive the other \$56 billion worth of services as uncompensated care.⁶ An estimated \$43 billion (75 percent) of the \$56 billion will be covered through various government subsidies. But government subsidies for uncompensated care are not necessarily distributed to health care providers in proportion to the uncompensated care they provide. Many hospitals and other local providers bear a disproportionate and substantial financial burden. The extent to which hospitals' unreimbursed costs are absorbed by hospitals or passed on in the form of higher charges to insured patients (as many believe to be the case) has not been adequately documented and should be the subject of further research.

There are stark differences in uninsurance rates across states, counties, and even zip codes within counties. Yet the problem of uninsurance may not affect all communities in the same way, even when rates of uninsurance are comparable. The dynamics are complex and not well understood. When a community has a high rate of uninsurance and subsidies fall short

⁵ In the discussion in this report, the term community refers to a group of people who (1) live in a particular geographic area, and (2) have access to a common set of health resources.

⁶ Uncompensated care is defined as all care not paid for out of pocket by the uninsured.

BOX S-4

Key Findings on the Health Effects of Uninsurance

Children benefit considerably from health insurance, as demonstrated by recent evaluations of enrollment in Medicaid and SCHIP programs:

- When previously uninsured children acquire insurance, their access to health care services, including ambulatory care, preventive health care (e.g., immunizations), prescription medications, and dental care improves.
- When previously uninsured children who are well or have special health needs acquire insurance, they are less likely to experience unmet health care needs. Uninsured children with special health care needs are much more likely to have an unmet health need than their counterparts with insurance.
- When previously uninsured children acquire insurance, they receive more timely diagnosis of serious health conditions, experience fewer avoidable hospitalizations, have improved asthma outcomes, and miss fewer days of school.

Adults benefit substantially from health insurance for preventive care when they are well and for early diagnosis and treatment when they are sick or injured:

- Without health insurance, men and women are less likely to receive effective clinical preventive services.
- Without health insurance, chronically ill adults are much more likely to delay or forgo needed health care and medications.
- Without health insurance, adults with cardiovascular disease or cardiac risk factors are less likely to be aware of their conditions, their conditions are less likely to be well controlled, and they experience worse health outcomes.
- Without health insurance, adults are more likely to be diagnosed with later-stage breast, colorectal, or other cancers that are detectable by screening or symptom assessment by a clinician. As a consequence, when uninsured adults are diagnosed with such cancers, they are more likely to die or suffer poorer health outcomes.
- Without health insurance, adults with serious conditions, such as cardiovascular disease or trauma, have higher mortality.
- The benefits of health insurance have been clearly demonstrated through recent studies of the experiences of previously uninsured adults after they acquire Medicare coverage at age 65. These studies demonstrate when previously uninsured adults gain Medicare coverage:
 - Their access to physician services and hospital care, particularly for adults with cardiovascular disease or diabetes, improves
 - Their use of effective clinical preventive services increases.
 - They experience substantially improved trends in health and functional status.
 - Their risk of death when hospitalized for serious conditions declines.

SUMMARY

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of costs, the financial impact on providers may be large enough to affect the availability and quality of local health care services for everyone, even for the people who have health insurance. Recent empirical analyses of the spillover effects of community uninsurance, including a study commissioned by the committee,⁷ suggest that when local rates of uninsurance are relatively high, *insured* adults are more likely to have difficulties obtaining needed health care and physicians may be more likely to believe that they are unable to make clinical decisions in the best interest of the patient without losing income.

The specific contribution of uninsurance to these problems is not known, but widespread problems in health care delivery in local communities, including disparities in the supply of physician services and other health care resources, may be exacerbated by the burden of uninsurance and have potentially grave implications for the quality and timeliness of care not only for people who lack health insurance, but also for people who have health insurance in those communities.

The committee's key findings on the community-level consequences of uninsurance are summarized in Box S-5. In sum, local health care delivery appears to be vulnerable to the financial pressures associated with high community-level uninsurance rates. Analyses commissioned by the committee and other recent research strongly suggest that when community-level uninsurance rates are relatively high, *insured* adults are more likely to have difficulties obtaining needed health care.

RECOMMENDATION OF THE COMMITTEE

The committee's findings demonstrate that the body of evidence on the health consequences of health insurance is stronger than ever before. There is a compelling case for urgent action. Simply stated: health insurance coverage matters. Expanding health coverage to all Americans is essential and should be done as quickly as possible. The President, Congress, and other leaders in the public and private sectors should act immediately to ensure that all individuals have health insurance. Without such action, preventable suffering due to the lack of health insurance promises to get worse rather than better.

The committee recommends that the President work with Congress and other public and private sector leaders on an urgent basis to achieve

⁷ Mark Pauly, Ph.D., and José Pagán, Ph.D., conducted original analyses of the effects of uninsurance on privately insured persons and local communities at the committee's request. The complete text of the commissioned analysis is available on the IOM website for the Health Insurance Status and Its Consequences project at <http://www.iom.edu/CMS/3809/54070.aspx>.

BOX S-5
Key Findings on the Consequences of High Community Uninsurance for People with Health Insurance

Local health care delivery appears to be vulnerable to the financial pressures associated with higher uninsurance. Analyses commissioned by the committee and other recent research strongly suggest that when community-level uninsurance rates are relatively high, *insured* adults are more likely to have difficulties obtaining needed health care and physicians are more likely to believe that they are unable to make clinical decisions in the best interest of the patient without losing income.

The empirical evidence indicates that higher community uninsurance is negatively associated with several well-validated indicators of access to and satisfaction with health care for *privately insured adults*, including:

- Having a place to go when sick, having a doctor's visit, visiting a doctor for routine preventive care, and seeing a specialist when needed.
- Satisfaction with the choice of primary care physician, being very satisfied with health care received during the last 12 months, trust that one's doctors put medical needs above all other considerations, and being very satisfied with the choice of specialist.

The Center for Studying Health System Change has documented growing economic disparities among U.S. communities with respect to geographic distribution of health care services, including new diagnostic and therapeutic techniques and technologies. The precise contribution of uninsurance to this dynamic is neither well understood nor readily measured. However, widespread problems in local health care delivery—not necessarily attributable to uninsurance—can be intensified by higher uninsurance rates.

For example:

- Providers and capital investment tend to locate in well-insured areas (and away from communities with high uninsurance). It is common for hospitals and clinics to focus major investments in more affluent locations with well-insured populations.
- Newer facilities with the most up-to-date technologies are a magnet for physician and other health care providers—this poses additional obstacles for financially stressed hospitals trying to recruit on-call specialists in high uninsurance areas.
- A number of hospital-based emergency care problems have serious implications for the quality and timeliness of care for insured as well as uninsured patients, including limits on inpatient bed capacity, outpatient emergency services, and timeliness of trauma care.

health insurance coverage for everyone and, in order to make that coverage sustainable, to reduce the costs of health care and the rate of increase in per capita health care spending.

There always has been, and will continue to be, uncertainty and disagreement about the best way to address major issues of public policy. The issue of cost, in particular, is daunting. But the nation has successfully addressed other complex issues that are intertwined with deeply held interests and ideologies. There is never a perfect opportunity for reform. This is the time to act, emboldened by the knowledge and compassion of a society that truly cares about its members and that has a history of tackling difficult problems.

Paying for health insurance coverage for all Americans will be expensive. The committee believes that steps to reduce the costs of health care and the rate of increase in per capita health care spending are of paramount importance if coverage for all is to be achieved and sustained. The committee does not believe that action should be delayed pending the development of a long-term solution to curbing underlying health care costs. Given the demonstrated harms of not having health insurance for children and adults, the committee believes that action to achieve coverage for all should proceed immediately, coupled with concerted attention to the long-term underlying trends in health care costs to assure sustainability of the system for all.

Health insurance coverage is integral to personal well-being and health. Despite the availability of some safety net services, there is a chasm between health care needs and access to effective health care services for uninsured children, adolescents, and adults. The committee agrees with the conclusion of our colleagues in the 2004 IOM report *Insuring America's Health*:

"...health insurance contributes essentially to obtaining the kind and quality of health care that can express the equality and dignity of every person. Unless we can ensure coverage for all, we fail as a nation to deliver the great promise of our health care system, as well as of the values we live by as a society. It is time for our nation to extend coverage to everyone."

America's Uninsured Crisis: Consequences for Health and Health Care

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1

Introduction

Abstract: This chapter describes the objectives, context, scope, and methods of this report. From 2001 to 2004, an earlier Institute of Medicine (IOM) committee undertook an exhaustive examination of the consequences of uninsurance and recommended that the nation move quickly to implement a strategy to achieve universal coverage. Five years later, the IOM Committee on Health Insurance Status and Its Consequences has reexamined the crisis of uninsurance in the United States, albeit with a more narrow focus. The objective of this report is to assess the more recent evidence on three fundamental 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?

In 2007, there were 45.7 million people without health insurance in the United States—nearly 1 in 5 adults under age 65 and more than 1 in 10 children (DeNavas-Walt et al., 2008). The fear of being without health insurance coverage is a growing strain on American families' sense of health and well-being (Schoen et al., 2008). Family concerns about losing health coverage are well founded.

Figure 1-1 shows changes in the percentage of nonelderly adults in the United States without health insurance from 1999-2000 to 2006-2007. In 2006-2007, in nine states (Arizona, Arkansas, California, Florida, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas)—up from just two states in 1999-2000—the percentage of nonelderly adults who did not have health insurance was 23 percent or more (Commonwealth Fund, 2008). In

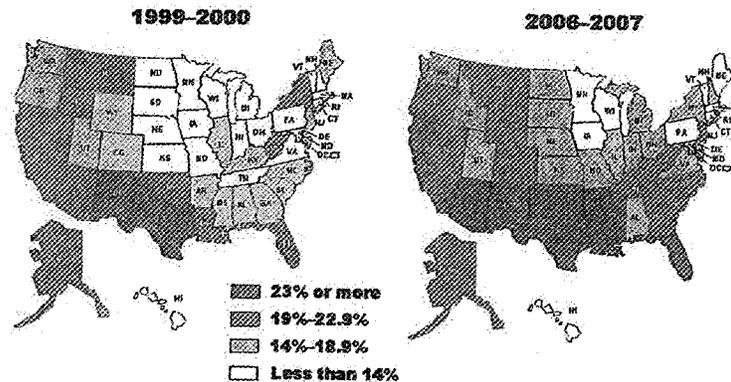


FIGURE 1-1 Comparison in the percentage of nonelderly adults without health insurance, by state, 1999-2000 and 2006-2007.
 SOURCE: The Commonwealth Fund (2008). Reprinted, with permission, from The Commonwealth Fund, 2008. Copyright 2008 by The Commonwealth Fund (<http://www.commonwealthfund.org>).

13 states (Alaska, Colorado, Georgia, Kentucky, Montana, Nevada, New Jersey, North Carolina, Oregon, South Carolina, Tennessee, West Virginia, and Wyoming), the percentage of nonelderly adults without health insurance ranged from 19 to 23 percent. Only 10 states (Connecticut, Hawaii, Iowa, Maine, Massachusetts, Minnesota, Pennsylvania, Rhode Island, Vermont, and Wisconsin) had uninsurance rates for nonelderly adults below 14 percent. As described in this report, rising health care costs, stagnant family incomes, fiscal pressures on state budgets, and increased unemployment are likely to drive further coverage declines (Baicker and Chandra, 2006; Chernew et al., 2005; Cooper and Schone, 1997; Holahan and Cook, 2008).

With a new administration and a new Congress, many citizens, policy makers, and opinion leaders anticipate renewed energy and interest in finding a way to reverse the erosion of health insurance coverage and, ultimately, to expand coverage to all in the United States (Blendon et al., 2008; Bodaken, 2008; Lake et al., 2008; McInturff and Weigel, 2008; Oberlander, 2007).

OBJECTIVE OF THE STUDY

The Robert Wood Johnson Foundation (RWJF) asked the Institute of Medicine (IOM) to reexamine America's uninsured crisis in order to inform the health reform policy debate as it unfolds in 2009 and beyond. The objective of this report is to evaluate the research evidence on the consequences of uninsurance that has emerged since the IOM conducted its earlier examination of the issues.

The question of whether health insurance matters to health is far more than an academic concern. It is crucial that U.S. health care policy be informed with current and valid evidence, especially for the 45.7 million individuals without health insurance. In recent years, researchers have considerably strengthened the body of evidence on the consequences of uninsurance, especially the consequences of uninsurance for health outcomes. Better quality longitudinal data and quasi-experimental methods have been used to assess how uninsurance affects the health and mortality of adults (Card et al., 2007; Decker, 2005; Dor et al., 2006; Finkelstein and McKnight, 2007; Hadley and Waidmann, 2006; McWilliams et al., 2007; Polsky et al., 2006; Volpp et al., 2003, 2005). There is also new evidence on the benefits of coverage for children and adolescents from well-designed studies of enrollment in public health insurance programs, such as the State Children's Health Insurance Program (SCHIP) and Medicaid (Davidoff et al., 2005; Halterman et al., 2008; Howell and Trenholm, 2007; Kempe et al., 2005; Kenney, 2007; Szilagyi et al., 2006; Trenholm et al., 2005).

WHAT IS THE PURPOSE OF HEALTH INSURANCE?

The health insurance system in the United States, in contrast with health insurance in almost all other industrialized nations, is essentially a voluntary one. Most Americans with private health insurance obtain it through the workplace. Employers are free to choose whether and what kind of insurance to offer their employees, and individuals in the United States are usually free to accept or decline their employers' offer of coverage, to purchase individual coverage, or if they are eligible, to enroll in public programs such as Medicare, Medicaid, or SCHIP.

Health insurance pools risk across groups of individuals or firms and then shares the cost of payouts among them, thereby reducing the burden of catastrophic costs for individual participants. Insurance is most effectively pooled across large groups. When individuals, families, or small employers do not have access to large group coverage, they must apply for coverage in the individual or small group markets. People are more likely to purchase and maintain coverage if they expect to incur high costs—a phenomenon referred to as adverse selection. Insurers protect against adverse selection

in the individual and small group health insurance markets by underwriting (i.e., assessment of applicants' health status and recent use of services). Thus, an insurer may completely deny coverage to applicants, impose permanent or temporary preexisting condition limitations on coverage, or charge a higher premium (depending on state insurance market regulations) on the basis of expected risk.

What is the purpose of health insurance? The answer depends on whose perspective is being considered:

- For consumers, health insurance often serves two purposes: (1) it provides a gateway to affordable health care through preferential pricing¹ of health care services and (2) it offers financial protection from unexpected health care costs.
- For clinicians, hospitals, and other health providers, health insurance ensures the financial stability of their operations. Indeed, health insurance as we know it today was first developed by Baylor University Hospital for exactly that purpose (Porter and Teisberg, 2006).
- With growing concern about the cost and quality of health care services, many large employers and purchasers of health benefits look to health insurance plans to encourage the use of beneficial, evidence-based services, particularly clinical preventive services such as childhood immunizations and certain adult cancer screening tests. Indeed, the quality of health insurance products is often assessed by measuring the extent to which the covered population receives such services (National Committee for Quality Assurance, 2008).

PREVIOUS IOM REPORTS ON UNINSURANCE

From 2001 to 2004, with the support of RWJF, the IOM issued a comprehensive series of six reports on the consequences of uninsurance for children, adults, families, communities, and the nation (IOM, 2001, 2002a,b, 2003a,b, 2004).² The series culminated with the publication in 2004 of *Insuring America's Health: Principles and Recommendations* (IOM, 2004). This report set out the IOM committee's vision and principles for health insurance coverage in the United States. It also included the committee's

¹ One recent analysis found that, for the same services, hospitals charge uninsured patients 2.5 times what they charge insurance companies and more than 3 times the hospital's Medicare-allowable costs (Anderson, 2007).

² For copies of the previous IOM report series on the consequences of uninsurance, please visit www.nap.edu.

BOX 1-1
The IOM's Past Findings and Recommendations Regarding Health Insurance Coverage in the United States, 2001-2004

In 2001, the IOM began a comprehensive 4-year study of the consequences of not having health insurance in the United States at the request of the Robert Wood Johnson Foundation.

From 2001 to 2004, the IOM published six reports that assessed the available evidence on how children, adults, families, communities, and the nation were affected by uninsurance. Among the principal findings in the earlier series of IOM reports on the consequences of uninsurance were the following:

- Children and adults without health insurance do not receive the care they need; they suffer from poorer health and development and are more likely to die early than children and adults who have coverage.
- Even one uninsured person in a family can put the financial stability and health of the whole family at risk.
- A high percentage of uninsured people within a community can adversely affect the overall health status of the community, its health care institutions and providers, and the access of its residents to key services.
- Recent federal initiatives to extend health insurance coverage have not closed the coverage gap.

The series concluded with the publication in 2004 of *Insuring America's Health: Principles and Recommendations*. In that report, the IOM Committee on the Consequences of Uninsurance recommended the following:

- The committee recommends that the President and Congress develop a strategy to achieve universal insurance coverage and to establish a firm and explicit schedule to reach this goal by 2010.
- The committee recommends that, until universal coverage takes effect, the federal and state governments provide resources sufficient for Medicaid and the State Children's Health Insurance Program (SCHIP) to cover all persons currently eligible and prevent the erosion of outreach efforts, eligibility, enrollment, and coverage.

SOURCE: IOM (2004).

recommendation that the nation move quickly to implement a strategy to achieve universal health insurance coverage. The key findings and recommendations of the 2004 report are provided in Box 1-1; the report's executive summary is presented in Appendix A.

As of early 2009, 5 years since the publication of the IOM's report *Insuring America's Health*, a comprehensive national plan to address America's uninsured crisis has yet to be enacted. A few states—most notably

Maine, Massachusetts, and Vermont—have achieved great progress towards the goal of universal health insurance coverage. Other states, including California, have attempted reforms but failed to move forward.

SCOPE AND METHODS OF THE STUDY

The scope of the earlier IOM series of studies on the consequences of uninsurance was broad and comprehensive: six published volumes assessed then-current evidence on the dynamics of health insurance coverage and the makeup of the uninsured population; effects of health insurance on health; implications for families including health and financial outcomes; impact on communities including the financing and delivery of health services, and community public health; economic and social implications such as spending and sources of spending on health care for the uninsured population including the estimated cost of expanding coverage, other costs including quality of life, family security, workforce participation and productivity; health systems impacts; and principles and strategies for extending coverage to all.

In contrast, the scope of this study is narrow and focuses on three essential questions (Box 1-2): (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?

BOX 1-2 Charge to the IOM Committee on Health Insurance Status and Its Consequences

The overarching objective of this study is to help inform the health reform policy debate as it unfolds in 2009. The committee will assess the research evidence—that has emerged since the IOM's 2001 to 2004 series of reports on uninsurance—on the consequences of uninsurance. Rather than performing a comprehensive review, the committee is charged with reviewing the literature to identify new insights not yet known or appreciated when the IOM's earlier reports were developed.

The search for new evidence will include the published literature on the consequences of uninsurance for individuals, families, communities, specific population groups, and safety net and other providers. The consequences may be related to health outcomes, such as morbidity and mortality; access to health care services; and economic impacts such as affordability of health coverage and its associated financing burden.

The IOM appointed the Committee on Health Insurance Status and Its Consequences to perform this study in April 2008. The 14-member committee included experts in analytic methods, public policy, vulnerable populations, employment-based health coverage, clinical medicine, health care delivery, health services research, health financing and economics, state health reform, and public health communication. Brief biographies of the committee members are presented in Appendix F.

The committee considered but excluded several topics from the study in order to optimize the depth and quality of its 6-month investigation into the three principal questions outlined above. Excluding these topics from this report should not be interpreted to mean they are unimportant. Indeed, these topics are inextricably linked with the nation's uninsured crisis and merit serious attention by policy makers. The omitted topics include the following: (1) The economic and financial impact of uninsurance. Health insurance has complex economic and financial implications for multiple aspects of American society—the productivity and financial stability of individuals, families, communities, health care systems and providers, American business, and local, state, and federal government. Related to these issues and also excluded from this study is the impact of uninsurance on household medical debt, the extent to which uninsurance affects the global competitiveness of American business, and whether providers shift the costs of uninsurance to private payers (a topic with only sparse and inconclusive evidence). (2) The effects of *underinsurance*. Uninsurance and underinsurance involve distinctly different policy issues, and the strategies for addressing them may differ. Uninsurance—the focus of this study—refers to the lack of health insurance coverage. Underinsurance is defined with respect to health insurance coinsurance requirements and coverage limitations, e.g., excessive out-of-pocket expenditures and/or significant limits on health care benefits perceived as essential to health (Collins et al., 2008; Davis, 2007; Oswald et al., 2007; Schoen et al., 2005, 2008; Wender, 2007). However, there is no agreed upon definition of underinsurance and an inadequate evidence base for assessing its impact (Blewett et al., 2006; Ward, 2006). (3) The impact of discontinuities in health insurance. Employers switch health plans with relative frequency, a new job typically results in different health coverage, and low-income individuals cycle in and out of eligibility for public health insurance. Even minimal disruptions in coverage—such as switching between types of coverage—have been shown to affect use of health care services (Bindman et al., 2008; Federico et al., 2007; Lavarreda et al., 2008; Leininger, 2009). (4) The study sponsor asked the committee not to explore potential approaches to expanding health coverage.

As the committee's work progressed, the committee became aware of considerable misinformation about uninsurance and its consequences, so that setting the record straight became an important concern. Perhaps fore-

most among these misconceptions is that charity care and other safety net services ensure that the health of uninsured individuals is protected—a belief that finds no significant support in the research evidence (as Chapter 3 will show). The committee also became aware that the continuing erosion of health insurance coverage was creating urgent difficulties for individuals, their communities, and public agencies that pay for health insurance coverage. It believes that 2009 will open a window of opportunity for addressing the problem.

The committee deliberated during four in-person meetings and seven conference calls between May and November 2008. The committee's initial deliberations focused on clarifying the scope of its work. The research conducted for this study was accomplished with the assistance of several consultants.³ Once the basic outline for the report was established, the committee commissioned two systematic reviews of research evidence on the consequences of not having health insurance for individuals: one review of the evidence on the consequences for children and adolescents and a second review on the consequences for adults. Both of these reviews of the research evidence focused on research published from 2002 to August 2008 in order to capture the evidence not available during the previous IOM examination of the relationship between health and health insurance. See Chapter 3 for details regarding the literature search strategy. The committee also commissioned original analyses of the Medical Expenditure Panel Survey, the household survey of the Community Tracking Study of the Center for Studying Health System Change, and the health insurance component of the Current Population Survey to examine trends in coverage and assess the impact of high rates of uninsurance on communities.

ORGANIZATION OF THE REPORT

This introductory chapter has described the context for this report, including the past IOM studies on uninsurance, the purpose of health insurance, the committee's charge, and the objectives, scope, and study methods for this report. Subsequent chapters address the following questions:

³ J. Michael McWilliams, M.D., Ph.D., reviewed the research evidence on the consequences of not having health insurance for adults, and Genevieve Kenney, Ph.D., and Embry Howell, Ph.D., reviewed the child and adolescent literature. Mark Pauly, Ph.D., and José Pagán, Ph.D., conducted an original analysis of the effects of uninsurance on privately insured persons and local communities. Jessica Banthin, Ph.D., Steve Cohen, Ph.D., and Joel Cohen, Ph.D., staff at the Agency for Healthcare Research and Quality, conducted original analyses of how uninsured families are burdened by the lack of health coverage. Additional details on the literature reviews and analyses commissioned by the committee are provided in subsequent chapters.

- Chapter 2—Caught in a Downward Spiral. What are the dynamics driving downward trends in health insurance coverage?
- Chapter 3—Coverage Matters. Is being uninsured harmful to the health of children and adults? What are the consequences of not having health coverage on access to care and health outcomes? Does the health of individuals without coverage improve when they become insured?
- Chapter 4—Communities at Risk. Are insured people affected by high rates of uninsurance in their communities?
- Chapter 5—Summary of Findings and Recommendation. What are the committee's key findings and recommendation?

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**BOX 4-2
What Is a Community?**

The term community, as used here, refers to a group of people who: (1) live in a particular geographic area, and (2) have access to a common set of health resources.

The term community can describe locations as small as neighborhoods and as large as metropolitan areas. How expansive a community is depends partly on the patterns of social, health care and economic interactions that are being analyzed. Thus, for example, the community that shares primary care resources such as physician practices and clinics may be relatively small and local, while the community sharing an advanced trauma care facility may encompass an entire metropolitan area and adjacent rural communities. The boundaries of a community can extend beyond where its residents live into where its residents work or routinely travel.

SOURCE: IOM (2003).

**CONTEXT FOR ASSESSING COMMUNITY-LEVEL
CONSEQUENCES OF UNINSURANCE**

The Burden of Providing Care to Uninsured Patients

Although there is no definitive accounting of the financial burden of uninsurance at the local or national level, it has been estimated that the annual cost of health services provided to uninsured people in the United States will total about \$86 billion in 2008 (Hadley et al., 2008). Uninsured patients will pay approximately \$30 billion for these services out of pocket and receive the other \$56 billion worth of services as uncompensated care.¹ An estimated \$43 billion (75 percent) of the \$56 billion will be covered through various government subsidies, including Medicare and Medicaid, disproportionate share hospital (DSH) payments, indirect medical education payments, direct care programs (e.g., community health centers), and state and local tax appropriations.

Payments for uncompensated care from the government are not necessarily distributed to health care providers in proportion to the uncompensated care they provide. Thus, many hospitals and other local providers bear a disproportionate and substantial financial burden due to their inability to receive adequate payment for the care they provide. Grady Memorial

¹ In this analysis, uncompensated care is defined as all care not paid for out of pocket by the uninsured.

BOX 4-3
Challenges at Grady Memorial Hospital in Atlanta

Grady Memorial Hospital is the only public hospital in Atlanta, Georgia, and the largest hospital in the state. An estimated one-third of Grady's patients are uninsured. The hospital receives substantial financial support from local Fulton and DeKalb counties and other public sources, but the subsidies fall short of the hospital's total costs for uncompensated care. Grady Memorial Hospital has run annual deficits for a decade. When this report was developed, the hospital estimated that its 2008 deficit would total \$51 million.

Because of continual losses, Grady has delayed capital projects, postponed updating clinical technology, curtailed investment in information technology, and faced difficulties recruiting nurses and pharmacists. The hospital recently reported that it needed \$370 million to overhaul operations, make capital improvements, and purchase basic diagnostic equipment, including X-ray machines, electrocardiogram and ultrasound devices, CT scanners, and MRI machines.

In 2006, Grady cared for 24 percent of Georgia's major trauma cases.* Many insured state residents may go elsewhere for routine health care services. But Grady is one of only four level-1 trauma centers in Georgia, and its service areas include a population of approximately 5.5 million people. Thus, when insured state residents experience severe trauma, they are likely to be transported to Grady.

* Personal Communication, G. Bishop, Bishop+Associates, October 29, 2008.

SOURCES: American College of Surgeons (2006); The Fulton-DeKalb Hospital Authority (2007); Grady Health System (2008a,b); Greater Grady Task Force (2007); Haley (2008).

Hospital illustrates how hospitals may be strained financially by the crisis in uninsurance and how financial burdens may threaten the quality of trauma and other care—even for patients who have health insurance (Box 4-3). The extent to which hospitals' unreimbursed costs are absorbed by hospitals or passed on in the form of higher charges to insured patients (as many believe to be the case) has not been adequately documented and should be the subject of further research.

Differences in Community-Level Uninsurance Rates

National trends in uninsurance rates, such as those discussed in Chapter 2, mask the tremendous variation in uninsurance rates across the United States. In 2007, for example, state-level uninsurance rates among the non-elderly population ranged from as low as 6 percent in Massachusetts to as high as 28 percent in Texas (U.S. Census Bureau, 2008a). Uninsurance rates in different counties within individual states also vary greatly, as shown in Figure 4-1.

Rural Poor Likely To Feel The Pinch Of State Decisions Not To Expand Medicaid

TOPICS: HEALTH REFORM, STATES, UNINSURED, MEDICAID, INSURANCE

SEP 03, 2013

Economist says half of the rural poor who would be aided by expansion live in states that have opted not to take that step.

The Associated Press: Economist: Medicaid Expansion A Rural Issue

Rural residents will likely benefit from the health care overhaul, but many will be hurt by their states' refusal to expand Medicaid coverage, a health economist said during a recent conference on rural health care. ... He told hospital administrators and others gathered in Milwaukee that when researchers look at rural residents who could be covered by expanded Medicaid, more than half live in states that have opted out. In comparison, more than half of the urban residents eligible for coverage under the expansion live in states that are going forward with it (Johnson, 8/2).

News outlets also looked at the issue of expansion as it plays out in several states.

Dallas Morning News: Study Says Texas Premiums Will Rise With Medicaid Expansion Opposition

Texas' refusal to expand Medicaid will cause private health insurance premiums to rise by an average of 9.3 percent for people who buy their own coverage, a new study finds. GOP lawmakers, strongly encouraged by Gov. Rick Perry, decided not to add poor adults to Medicaid's rolls. That means about 1.3 million fewer Texans will have health coverage by 2016 than if the federal Affordable Care Act were fully implemented in the state, according to the study by the nonprofit research organization Rand Corp. (Garrett, 9/2).

The Columbus Dispatch: Group Gathering Signatures For Medicaid Expansion Ballot Initiative

Frustrated with GOP leaders refusal to act on [Ohio] Gov. John Kasich's proposed Medicaid expansion, advocates for the uninsured have begun collecting signatures which could send the issue to the ballot for voters to decide. The effort is being led by a broad-based coalition made up of businesses, unions, health-care providers religious organizations, consumer groups and advocates for the uninsured (Candisky, 8/31).

The Associated Press: Medicaid Debate Turns To When Expansion Occurs

The Michigan Senate's intense, months-long debate over Medicaid expansion and the federal health care law is not over, even after the Republican-controlled chamber's milestone vote to provide health insurance to hundreds of thousands of low-income residents. Senators on Tuesday will reconsider the issue of when the legislation should take effect (Eggert, 9/1).

Detroit Free Press: Michigan's Medicaid Expansion A Relief For Hospitals Giving Unpaid Care

Hospitals administrators across the state are hopeful that since the Medicaid expansion bill cleared its biggest hurdle last week, they can recoup some of the hundreds of millions of dollars they lose each year providing uncompensated health care to poor and uninsured patients. ... several of the systems that serve large numbers of low-income patients, including Henry Ford Health System and St. John Providence Health System, estimated they will save roughly 10 to 15 percent on the amounts they lose each year to uncompensated care — free charity care, unpaid patient bills and services provided to uninsured people at reduced prices (Reindi, 9/2).

Meanwhile, one outlet looks at changes coming in Michigan with the new online health marketplaces -

Detroit Free Press: Companies And Organizers Prep For Michigan Exchange Rollout Oct. 1

Nearly every Michigander will have access to basic health insurance — and be required to get it — beginning Oct. 1 as federal health reform's largest provisions start snapping into place with the launch of each state's Health Insurance Marketplace. For those with no insurance or bare-bones coverage, that could mean more generous benefits than they've ever had, once coverage becomes effective Jan. 1 (Erb, 9/1).

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Bloomberg

Hospitals Brace as Republicans Fight Over Medicaid

By Mark Niquette and Brian Chappatta - Sep 19, 2013

Phil Ennen runs a rural hospital system in northwest Ohio that admits about 2,500 people a year, many of them poor or elderly. He's got the only emergency cardiac catheterization lab between Toledo and Fort Wayne, Indiana.

Ennen estimates he'd be out \$1.3 million a year and struggle to stay independent if business groups and Governor John Kasich can't persuade fellow Republicans to expand Medicaid to cover more poor people under President Barack Obama's Affordable Care Act.

"I don't have any time to be political about this," Ennen, 50, said in a telephone interview from Bryan. "I'm going to have people walking through our door needing care who should have a source of payment and won't, and that's frustrating."

Ohio is among U.S. states where Tea Party Republicans have blocked Medicaid expansion, in some cases over the objections of other Republicans and business lobbies that have traditionally supported the party. Hospital leaders say the cost will be lost payments and jobs. The financial effect is evident: Facilities in states broadening the program are already enjoying lower borrowing costs.

The fight reflects an intensifying rift between business and the Tea Party over high-profile issues, said John Green, a University of Akron political-science professor. Besides Medicaid, they include efforts in states including Indiana and North Carolina to halt or delay Common Core education standards to prepare students for college or careers, the right to bring guns to work in Alabama and on immigration in several places.

Breaking Ranks

"Once upon a time, if the big economic interests said, 'This is what we're for,' almost all Republicans would get in line," Green said in a telephone interview. "The calculus is just a lot different today."

Twenty-five states and the District of Columbia are proceeding with Medicaid expansion, including eight with Republican governors. Twenty-two aren't and debate is continuing in New Hampshire, Ohio and Tennessee, according to the Kaiser Family Foundation, a nonprofit group that studies health in Menlo Park, California.

State Lines

In Ohio, a presidential battleground that Obama won twice, Republicans control all statewide offices and the legislature. Its lawmakers have blocked a push to expand Medicaid by Kasich, the state Chamber of Commerce and groups including the anti-abortion organization Ohio Right to Life.

A coalition of business groups is collecting signatures to force a referendum on the question next year if lawmakers won't act, and Kasich is considering ways to open the program without a vote by the full legislature.

If all states participated in the Medicaid expansion, hospitals would see a \$12.5 billion spending boost in 2014, according to an analysis by Bloomberg Government. About \$7.8 billion, or 63 percent, won't be spent in the 25 states that have so far decided not to expand. The increased spending in Ohio would be \$458.4 million, the analysis said.

Ohio hospitals will lose \$7.4 billion during the next decade from reduced reimbursements if the state doesn't expand Medicaid, said Mike Abrams, president of the Ohio Hospital Association. Hospitals that are the largest employers in 78 of Ohio's 88 counties may fire employees or close, he said.

Moral Case

Ennen's system employs 750 people with net revenue of \$80 million a year. He complains about the possibility of curtailing services while hospitals across the state line 20 miles (31 kilometers) north don't, because Michigan is broadening Medicaid.

Kasich, 61, a first-term governor and former congressman and Fox Television host who opposed Obama's health-care law, has argued that Medicaid expansion makes sense.

Ohio would recapture about \$13 billion in tax dollars over seven years and hospitals would benefit, he has said. The governor has also said that covering an additional 275,000 people -- especially those needing care for mental health or drug addiction -- is moral issue. They are, he said, "the least among us."

"We can deal with our federal budget deficit despite the fact that we're doing something on Medicaid," Kasich, a U.S. House Budget Committee chairman in the 1990s when the federal budget was balanced, told reporters in Columbus on Sept 16. "It can be done."

Covering Action

The governor is trying to appeal to independents for his re-election in 2014, while business groups and the "hospital-industrial complex" are exaggerating to get "free money," said Matt Mayer, president of Opportunity Ohio, a Columbus group that promotes free markets.

"It doesn't solve the business problem, which is how do we make sure that our vulnerable populations who truly need medical care and access thereto that's affordable, get it?" Mayer said by phone. He called hospitals' threats "a scare tactic," and said states opposing expansion are saving the nation billions of dollars.

Even so, investors in the \$3.7 trillion municipal-debt market are already penalizing bonds from hospitals in states that aren't expanding Medicaid compared with those in states that are.

Sweet Deal

Securities sold for Ohio's Akron Children's Hospital that mature in 2038 traded Sept. 13 at an average yield that was 0.85 percentage point more than benchmark AAA munis, data compiled by Bloomberg show. The penalty on the debt, rated A+ by Standard & Poor's, has widened by 15 percent since July 31, the data show.

During the same period, the spread on bonds for Sparrow Health System in Michigan, which voted to expand Medicaid, increased just 2 percent, the data show. The securities are due in 2036 and share the same S&P rating as the Ohio debt.

Rising yield premiums -- the amount investors demand to hold the bonds -- reflect higher costs Ohio health systems are set to face when they next offer debt. For a hospital that issues \$100 million and repays the loan over 30 years, the difference between paying a 5 percent interest rate and one that's 0.25 percentage point higher represents an extra \$7.5 million in debt service.

"There should be some benefit to hospitals in states that are going forward with Medicaid expansion," said Lisa Martin, an analyst who covers municipal health-care issuers for New York-based Moody's Investors Service.

Home Front

Republican leaders who cater too much to business are out of step with the rank and file, said Whitney Neal of FreedomWorks, a Washington-based group connected with the Tea Party movement.

"You're seeing the guys that care about their constituents versus the guys that care about the people who they're beholden to, the special interest groups," Neal said in a telephone interview.

Supporting issues such as Medicaid expansion could draw a primary opponent for Republican lawmakers in conservative districts, Green said. The ability of party leaders to influence policy also has waned as social media and technology connected conservatives and gave them a platform, said Kevin Madden, a Republican strategist in Washington who advised Mitt Romney's 2012 presidential campaign.

"Technology has really empowered a lot of grassroots voices within the party," Madden said in a telephone interview. "As a result, I think that they've gained a much greater market share of influence in these debates in states and in Washington."

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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.

ABSTRACT

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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MEDICAID CURRENTLY INSURES 60 million people, and the Affordable Care Act (ACA) will extend Medicaid eligibility to millions more starting in 2014.¹ The recent Supreme Court ruling enables states to choose whether to expand Medicaid under the ACA, and many states facing budget pressures are considering cutbacks instead.² Yet evidence regarding Medicaid's effect on health remains surprisingly sparse, particularly for adults. Previous research showed that Medicaid expansions in the 1980s reduced mortality among infants and children,^{3,4} though other studies showed little effect.⁵⁻⁷ Numerous observational studies have documented a correlation between Medicaid coverage and adverse outcomes among adults,^{8,9} prompting some observers to claim that Medicaid coverage is worse than no coverage.^{10,11} However, such studies are plagued by unmeasured confounders that make Medicaid patients sicker than others.¹² One ongoing randomized trial of an expansion of Medicaid in Oregon showed significant improvements in self-reported health and access to care in the first year.^{13,14}

Traditionally, Medicaid covers only low-income children, parents, pregnant women, and disabled persons. During the past decade, however, several states have expanded Medicaid to cover nondisabled adults without dependent children ("childless adults"), a group that is similar to the population gaining eligibility under the ACA (i.e., all adults with incomes up to 138% of the federal poverty level). We used this natural experiment to determine whether state expansions of Medicaid were associated with decreased mortality. We hypothesized that Medicaid expansions would reduce mortality, rates of uninsurance, and cost-related barriers to care and would improve self-reported health, particularly among minority and lower-income populations.

METHODS

STUDY DESIGN

We used a differences-in-differences quasi-experimental design that incorporated data before and after Medicaid expansions in both the expansion states and the control states. We identified states that had implemented major Medicaid expansions to cover childless adults (19 to 64 years of age) between 2000 and 2005, allowing analysis of multiple years of post-expansion data.¹⁵ Three states met our criteria: Arizona, which expanded

eligibility to childless adults with incomes below 100% of the federal poverty level in November 2001 and to parents with incomes up to 200% of the federal poverty level in October 2002¹⁶; Maine, which expanded eligibility to childless adults with incomes up to 100% of the federal poverty level in October 2002¹⁷; and New York, which expanded eligibility to childless adults with incomes up to 100% of the federal poverty level and parents with incomes up to 150% of the federal poverty level in September 2001.¹⁸

Our study period included 5 years before and 5 years after each state's expansion, with the post-intervention period beginning the first full year after the expansion to cover childless adults and the preintervention period covering the immediately preceding 5 years. We selected as controls neighboring states without major Medicaid expansions that were closest in population and demographic characteristics to the three states with Medicaid expansions¹⁵: New Hampshire (for Maine), Pennsylvania (for New York), and Nevada and New Mexico (for Arizona). (Details are provided in the Supplementary Appendix, available with the full text of this article at NEJM.org.)

OUTCOMES AND DATA

The primary outcome was annual county-level all-cause mortality per 100,000 adults between the ages of 20 and 64 years (stratified according to age, race, and sex), obtained from the Compressed Mortality File of the Centers for Disease Control and Prevention (CDC) from 1997 through 2007, totaling 68,012 observations specific to an age group, race, sex, year, and county. County-level, year-specific rates of poverty and unemployment, as well as median household income, were obtained from the Area Resource File.¹⁹ In the primary analysis, we excluded 19-year-olds (since they are grouped by the CDC with teenagers, 15 to 19 years of age), although 19-year-olds were included in subsequent analyses.

Secondary outcomes were the percentages of persons with Medicaid, without any health insurance, and in "excellent" or "very good" health (from the Current Population Survey, a total of 169,124 persons) and the percentage unable to obtain needed care in the past year because of cost (from the Behavioral Risk Factor Surveillance System, a total of 192,148 persons). Both data sets are nationally representative annual household surveys. The study sample included adults be-

tween the ages of 19 and 64 years. The outcome among persons in the Behavioral Risk Factor Surveillance System was not measured in the 2001 and 2002 surveys, so we added years to maintain 5 years of data before and after Medicaid expansions for this measure.

STATISTICAL ANALYSIS

We examined unadjusted and adjusted results for our primary and secondary outcomes over time, comparing expansion and control states. For our core analyses, we used multivariable regression, with a generalized linear model and Huber-White robust standard errors clustered at the state level, to account for the state-level intervention and serial autocorrelation.²⁰ The independent variable of interest was the interaction between timing after Medicaid expansion and expansion state, which compared the average difference in mortality between expansion and control states in the period before Medicaid expansion with that after expansion, with adjustment for covariates and county and year fixed effects.

We analyzed the primary outcome on the basis of annual county-level mortality data (stratified according to age, sex, and race), since the CDC does not release individual-level mortality data. Regression equations for analysis of mortality were adjusted for age, sex, and race; for the Latino proportion of each county's population; for county-year economic covariates; and for a set of interactions between each pair of expansion-control states and year, allowing each expansion-control pairing to have its own time trend (for details, see the Supplementary Appendix). We adjusted for time-invariant confounders, such as rural versus urban setting and environmental factors, through the use of county fixed effects. All analyses were weighted according to population size.

We conducted prespecified subgroup analyses, with the sample divided according to race (white vs. nonwhite; Latino ethnic background was not measured in mortality data before 1999), age (20 to 34 years vs. 35 to 64 years, since mortality rises significantly after the age of 35 years) (Table S1 in the Supplementary Appendix), county poverty rate (divided at the population mean of 10%), and each expansion state. We compared causes of death, using the CDC's classification of external causes (injuries, suicide, homicide, complications of medical treatment, and sub-

stance abuse) versus internal causes (all other causes).²¹

For secondary outcomes, the unit of analysis was the individual. We adjusted for age, sex, race or ethnic group, income, state, and interactions between year and expansion-control pairing, using a generalized linear model and robust standard errors clustered at the state level.

Lastly, we used Current Population Survey data to derive descriptive statistics for the additional persons who enrolled in Medicaid as a result of the expansions, in order to assess which persons were most likely to enroll during an eligibility expansion. We compared the mean age, sex, race or ethnic group, and self-reported health status of persons enrolled before expansion and those enrolled after expansion, imputing the characteristics of new enrollees on the basis of changes in those measures.

We conducted several sensitivity analyses of mortality, including an examination of differences between expansion and control states before Medicaid expansion, alternative regression models, state-level instead of county-level mortality, and exclusion of particular years (for details, see the Supplementary Appendix). We explored potential bias from the CDC's bottom-coding of county subsamples with low death counts, which occurs for any subsample with one to five deaths per year to protect confidentiality (i.e., 4.7% of our weighted sample), by testing alternative imputation methods.²² Although the Huber-White correction has a number of advantages²⁰ and is often used in similar circumstances,²³⁻²⁵ it does not perform optimally with small numbers of clusters (i.e., the seven states in our analysis). To investigate the sensitivity of the statistical significance of our findings, we tested several alternative standard errors.²⁹

As an additional test of our quasi-experimental design, we repeated our main analyses among adults who were 65 years of age or older, whose Medicaid eligibility was not affected by the expansions. We then estimated a differences-in-differences model to assess changes in mortality, in expansion states versus control states, among persons between the ages of 20 and 64 years as compared with those 65 years of age or older. Given the markedly different baseline rates of death between the younger and older age groups (320 vs. 4800 deaths per 100,000), this analysis used a logarithmic regression model.

Table 1. Characteristics of the Study Sample at Baseline.*

Characteristic	Medicaid Expansion States	Control States
Mean (\pm SD) age (yr)	39.7 \pm 12.2	40.4 \pm 12.0
Age group (%)		
19–24 yr	13.4 \pm 0.3	12.3 \pm 0.3
25–34 yr	23.9 \pm 0.4	21.6 \pm 0.4
35–44 yr	26.8 \pm 0.4	27.9 \pm 0.4
45–54 yr	21.4 \pm 0.3	22.9 \pm 0.4
55–64 yr	14.5 \pm 0.3	15.3 \pm 0.4
Male sex (%)	48.2 \pm 0.2	48.8 \pm 0.3
Race or ethnic group (%)†		
White	81.2 \pm 0.5	88.6 \pm 0.5
Nonwhite	18.8 \pm 0.5	11.4 \pm 0.5
Latino	16.1 \pm 0.4	7.4 \pm 0.2
Income (%)		
<100% of FPL	13.1 \pm 0.3	10.1 \pm 0.3
100–200% of FPL	28.9 \pm 0.4	24.3 \pm 0.5
Mortality (deaths/100,000 population)‡		
Total	320 \pm 2.8	344 \pm 2.8
From internal causes	275 \pm 2.7	288 \pm 2.7
From external causes	50 \pm 0.6	67 \pm 0.7

* Plus–minus values are means \pm SE unless otherwise indicated. Between-group differences in all categories were significant ($P<0.01$). Demographic data are from the Current Population Survey (70,016 persons from years before Medicaid expansion). FPL denotes federal poverty level.

† Race and ethnic group were reported separately in Census data.

‡ Mortality data were obtained from the Compressed Mortality File at the county level in 32,752 county-year subsamples. External causes included injuries, suicide, homicide, complications of medical treatment, and substance abuse, and internal causes included all other causes. The numbers of deaths that are listed according to diagnosis do not sum to the total number of deaths because of imputation of bottom-coded values.

RESULTS

CHANGES IN MORTALITY

The demographic characteristics of expansion and control states were substantively similar but differed statistically because of the large sample (Table 1). Baseline mortality was 320 deaths per 100,000 adults in expansion states and 344 per 100,000 in control states, with more than 80% of deaths from internal causes (as defined in the Methods section). Figure 1 presents unadjusted results for all-cause mortality and Medicaid coverage in the expansion and control states (see Fig. S1, S2, and S3 in the Supplementary Appendix for other outcomes). The Medicaid expansion was associated with a significant decrease in un-

adjusted mortality (by 25.4 deaths per 100,000, $P=0.02$) and a significant increase in Medicaid coverage (by 2.2 percentage points, $P=0.01$).

Table 2 presents the net change after Medicaid expansion in adjusted all-cause mortality in expansion states, as compared with control states. Mortality declined significantly (by 19.6 deaths per 100,000, for a relative reduction of 6.1%; $P=0.001$). Reductions were greatest among nonwhites and older adults, with smaller but significant reductions among whites and no effect among persons under the age of 35 years. Counties with higher poverty rates had larger mortality reductions. Single-state analyses showed significant effects only in the largest state, New York. For each of the three states, the 95% confidence interval included the estimate for the overall sample (although Maine's imprecise estimate differed significantly from that of New York).

In sensitivity analyses, there were small, non-significant differences in mortality trends between expansion and control states before Medicaid expansion, with a reduction of 1.0 death per 100,000 per year ($P=0.07$) and a reduction of 1.6 deaths per 100,000 per year with the exclusion of year 0 as a transitional year ($P=0.23$) (Table S2 in the Supplementary Appendix). Results were robust with respect to alternative functional forms, analysis of state-level versus county-level mortality, exclusion of year 0, imputation methods for bottom-coded death counts, alternative approaches to calculating standard errors, and restricted subsamples of years to limit serial autocorrelation ($P<0.05$ for all comparisons). The interrupted time-series model showed an increasing effect of Medicaid expansion over time, with a reduction of 6.5 deaths per 100,000 per year ($P=0.006$). Analyses that were performed according to the cause of death showed significant reductions in both deaths from internal causes (by 13.2 deaths per 100,000, for a relative reduction of 4.8%; $P=0.001$) and deaths from external causes (by 3.8 deaths per 100,000, for a relative reduction of 7.6%; $P=0.001$).

OTHER CHANGES ASSOCIATED WITH EXPANSION

Table 3 presents changes in insurance, access to care, and health. Medicaid expansions were associated with a significant increase in Medicaid coverage (by 2.2 percentage points, for a relative increase of 24.7%; $P=0.01$), a significant decrease in uninsurance (by 3.2 percentage points, for a relative decrease of 14.7%; $P<0.001$), a sig-

nificant decrease in the rate of delayed care because of cost (by 2.9 percentage points, for a relative decrease of 21.3%; $P=0.002$), and a significant increase in rates of "excellent" or "very good" health (by 2.2 percentage points, for a relative increase of 3.4%; $P=0.04$). Increases in Medicaid coverage in the expansion states were concentrated among low-income adults, whereas reductions in uninsured rates were significant for both lower- and higher-income groups. Reductions in cost-related delays in care were significant for all subgroups.

NEW ENROLLEES

Table 4 provides imputed statistics for the additional persons who enrolled in Medicaid because of the expansions, as compared with the general adult population (see the Supplementary Appendix for calculations). New Medicaid enrollees were older than the general population (mean age, 40.6 vs. 40.0 years), disproportionately male (57% vs. 49%), nonwhite (27% vs. 20%), and in fair or poor health (20% vs. 11%) ($P<0.001$ for all comparisons).

ELDERLY ADULTS

Among persons 65 years of age or older, Medicaid expansions were associated with a small but significant reduction in the uninsured rate (by 0.4 percentage points, $P=0.007$), a significant decline in cost-related delays in care (by 2.3 percentage points, $P=0.001$), and a significant reduction in absolute mortality (by 127 deaths per 100,000, for a relative reduction of 2.6%; $P<0.001$) (Table S3 in the Supplementary Appendix). The inclusion of elderly adults as an additional control group for nonelderly adults in a differences-in-differences-in-differences model decreased the estimated mortality reduction among the nonelderly by approximately one third, and the effect remained significant ($P=0.03$).

DISCUSSION

Our study documents that large expansions of Medicaid eligibility in three states were associated with a significant decrease in mortality during a 5-year follow-up period, as compared with neighboring states without Medicaid expansions. Mortality reductions were greatest among adults between the ages of 35 and 64 years, minorities, and residents of poor counties. These findings may influence states' decisions with respect to Medicaid expansion under the ACA.

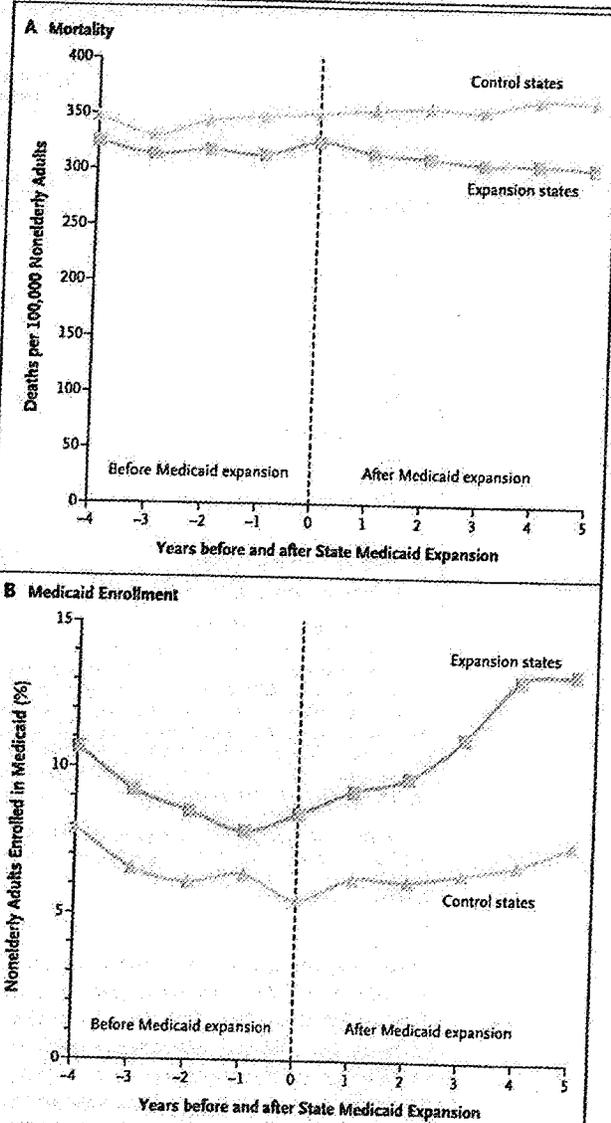


Figure 1. Unadjusted Mortality and Rates of Medicaid Coverage among Nonelderly Adults before and after State Medicaid Expansions (1997-2007). The vertical line represents the year during which the Medicaid expansions were implemented, meaning that year 1 was the first full year after the expansions (2002 for Arizona and New York and 2003 for Maine). In unadjusted models, the expansions were associated with a significant decrease in all-cause mortality in expansion states, as compared with control states (-25.4 deaths per 100,000 population; 95% confidence interval [CI], -46.0 to -4.8; $P=0.02$) (Panel A) and a significant increase in Medicaid coverage (by 2.2 percentage points; 95% CI, 0.7 to 3.7; $P=0.01$) (Panel B). Data for adults between the ages of 20 and 64 years are included in Panel A and data for those between the ages of 19 and 64 years in Panel B, owing to differences in the two data sets.

Table 2. Changes in All-Cause Mortality among Adults between the Ages of 20 and 64 Years in States with Medicaid Expansions.*

Variable	Baseline Mortality in States with Expansion <i>no. of deaths/100,000</i>	Net Change in Mortality after Expansion† <i>no. of deaths/100,000 (95% CI)</i>	P Value for Difference between Subgroups
Full sample	320	-19.6 (-27.3 to -11.9)‡	NA
Race§			
White	309	-14.0 (-19.8 to -8.2)‡	0.04
Nonwhite	361	-41.0 (-64.7 to -17.3)¶	Reference
Age			
20-34 yr	83	1.0 (-12.8 to 14.8)	0.006
35-64 yr	446	-30.4 (-41.0 to -19.9)‡	Reference
Level of poverty in county			
High	334	-22.2 (-31.0 to -13.5)‡	0.01
Low	283	-11.3 (-19.2 to -3.3)‡	Reference
State			
Maine (vs. New Hampshire)	306	13.4 (-27.5 to 54.3)	0.01
Arizona (vs. Nevada and New Mexico)	332	-10.2 (-32.7 to 12.3)	0.18
New York (vs. Pennsylvania)	317	-22.2 (-39.1 to -5.2)‡	Reference

* The primary outcome was all-cause county-level mortality among 68,012 county-year subsamples in the Compressed Mortality File of the CDC. All analyses were adjusted for race, sex, age, county poverty rate, county median income, county unemployment rate, Latino proportion of county's population, year, county, state of residence, and interactions between year and expansion-control pairing. Full regression equations and coefficients for covariates are reported in the Supplementary Appendix. NA denotes not applicable.

† The data that are shown represent the net change in mortality after the Medicaid expansion was implemented (i.e., the adjusted before-after change in the expansion states minus the before-after change in the control states).

‡ P<0.001.

§ Latino ethnic background was not reported in mortality statistics before 1999, so listed data were not stratified according to this variable. However, adjustments were made for the Latino proportion of each county's population.

¶ P<0.01.

‡ P<0.05.

Our study shows a mortality reduction associated with state Medicaid expansions to cover adults. Using state-level differences in Medicaid expansion as a natural experiment avoids the confounding between insurance and individual characteristics (e.g., poverty or health status) that plagues cross-sectional observational studies. These results build on previous findings that Medicaid coverage reduces mortality among infants and children^{3,4} and are consistent with preliminary results of a randomized, controlled trial of Medicaid in Oregon, which showed significant improvement in self-reported health during the first year (although objective measures of health are not yet available and 1-year mortality effects were not significant and were imprecisely estimated).¹⁴

We observed reductions in deaths from both

internal and external causes. The relative mortality reduction was higher for external causes of death than for internal causes, though this difference was not significant. We hypothesized that internal causes would be more amenable to intervention through improved risk-factor management and medication adherence,³⁰ though a study involving persons who were hospitalized after accidental injuries showed a reduction of nearly 40% in mortality among insured adults, as compared with uninsured adults, because of a greater intensity of care and longer lengths of stay.³¹

Our secondary analyses provide a plausible causal chain for reduced mortality that is consistent with previous research,^{32,33} with eligibility expansions associated with a 25% increase in Medicaid coverage, 15% lower rates of uninsured

MORTALITY AFTER STATE MEDICAID EXPANSIONS

Table 3. Changes in Insurance Coverage, Access to Care, and Health among Adults between the Ages of 19 and 64 Years after State Medicaid Expansions.*

Variable	Net Change after Expansion			
	Medicaid Coverage†	No Health Insurance†	Delayed Care Because of Cost‡	Self-Reported Excellent or Very Good Health†
	<i>percentage points (95% CI)</i>			
Full sample	2.2 (0.1 to 3.8)§	-3.2 (-4.0 to -2.4)¶	-2.9 (-4.2 to -1.5)¶	2.2 (0.0 to 4.3)§
Race				
White non-Latino	2.0 (0.6 to 3.4)§	-3.3 (-4.9 to -1.8)¶	-3.2 (-4.7 to -1.6)¶	2.0 (0.0 to 4.0)§
Nonwhite and Latino	2.6 (0.1 to 5.2)§	-2.8 (-5.9 to 0.0)	-2.4 (-3.7 to -1.0)¶	2.3 (-0.1 to 5.6)
Age				
19-34 yr	2.6 (0.1 to 4.7)§	-2.7 (-4.1 to -1.4)¶	-3.4 (-3.9 to -1.2)¶	1.7 (-0.1 to 4.4)
35-64 yr	2.0 (0.1 to 3.3)§	-3.5 (-4.6 to -2.3)¶	-2.6 (-3.9 to -1.2)¶	2.5 (0.4 to 4.5)§
Income (%)‡				
<200% of FPL or <\$35,000	5.4 (1.1 to 9.8)§	-4.5 (-7.2 to -1.8)¶	-2.9 (-5.3 to -0.1)§	4.1 (0.0 to 8.2)
≥200% of FPL or ≥\$35,000	1.1 (-0.1 to 2.2)	-2.5 (-3.8 to -1.3)¶	-2.8 (-3.9 to -1.8)¶	1.3 (-0.1 to 3.1)

* The data shown represent the net change in each outcome after the Medicaid expansion was implemented (i.e., the adjusted before-after change in the expansion states minus the before-after change in the control states). All analyses were adjusted for year, state of residence, sex, race or ethnic group, age, family income (as a percentage of the federal poverty level [FPL] in the Current Population Survey), total household income and family size (in the Behavioral Risk Factor Surveillance System), and interactions between year and expansion-control pairing.

† Results are based on an evaluation of 169,124 persons in the Current Population Survey.

‡ Results are based on an evaluation of 192,148 persons in the Behavioral Risk Factor Surveillance System.

§ P<0.05.

¶ P<0.01.

‡ The Current Population Survey provides income data as a percentage of the FPL, but this information is not available in the Behavioral Risk Factor Surveillance System, which provides household income only in increments of \$10,000 to \$15,000. For the Current Population Survey, the cutoff of 200% of FPL was used. For Behavioral Risk Factor Surveillance System, \$35,000 in annual income was selected as the cutoff, and Current Population Survey data suggest that this cutoff should capture nearly 93% of families at or below 200% of FPL in the sample.

ance, a 21% reduction in cost-related delays in care, and a 3% increase in self-reported excellent or very good health. However, it is not clear whether the magnitude of these changes is sufficient to account for the observed mortality reduction, and these associations do not prove causality.

Our estimate of a 6.1% reduction in the relative risk of death among adults is similar to the 8.5% and 5.1% population-level reductions in infant and child mortality, respectively, as estimated in analyses of Medicaid expansions in the 1980s.³⁴ Our results correspond to 2840 deaths prevented per year in states with Medicaid expansions, in which 500,000 adults acquired coverage.¹⁵ This finding suggests that 176 additional adults would need to be covered by Medicaid in order to prevent 1 death per year.

A relative reduction of 6% in population mortality would be achieved if insurance reduced the

individual risk of death by 30% and if the 1-year risk of death for new Medicaid enrollees was 1.9% (Table S4 in the Supplementary Appendix). This degree of risk reduction is consistent with the Institute of Medicine's estimate that health insurance may reduce adult mortality by 25%,³⁴ though other researchers have estimated greater³⁵ or much smaller³⁶ effects of coverage. A baseline risk of death of 1.9% approximates the risk for a 50-year-old black man with diabetes^{37,38} or for all men between the ages of 35 and 49 years who are in self-reported poor health.³⁹ The lower end of our confidence interval implies a relative reduction in the individual risk of death of 18%.

For Medicaid expansions to produce effects of this size, new enrollees must have had a higher-than-average risk of death that was responsive to medical care. We found that new Medicaid enrollees were older, disproportionately minorities, and

Table 4. Imputed Characteristics of New Medicaid Enrollees after Medicaid Expansions, as Compared with the General Population.*

Variable	New Medicaid Enrollees (N=9431)	General Population (N=67,837)
Mean (\pm SD) age (yr)	40.6 \pm 12.2	40.0 \pm 12.2
Age group (%)		
19–24 yr	13.8 \pm 0.4	13.5 \pm 0.2
25–34 yr	21.0 \pm 0.4	23.7 \pm 0.2
35–44 yr	22.0 \pm 0.4	25.7 \pm 0.2
45–54 yr	29.4 \pm 0.5	22.1 \pm 0.2
55–64 yr	13.7 \pm 0.4	15.6 \pm 0.2
Male sex (%)	57.0 \pm 0.5	48.6 \pm 0.2
Self-reported health status (%)		
Excellent	24.5 \pm 0.4	30.3 \pm 0.2
Very good	34.6 \pm 0.5	34.6 \pm 0.2
Good	21.0 \pm 0.4	24.4 \pm 0.2
Fair or poor	20.0 \pm 0.4	10.8 \pm 0.1
Race or ethnic group (%)		
White	73.2 \pm 0.5	79.9 \pm 0.2
Nonwhite	26.8 \pm 0.5	20.1 \pm 0.2
Latino	27.4 \pm 0.5	16.9 \pm 0.1

* Plus-minus values are means \pm SE unless otherwise indicated. All differences between new Medicaid enrollees and the general population were significant ($P<0.001$). New enrollees were identified on the basis of differences in the demographic characteristics of adults before and after expansion in the Medicaid expansion states, according to data from the Current Population Survey. The general population refers to all adults between the ages of 19 and 64 years in expansion states during the study period. P values were calculated with the use of survey-weighted Pearson chi-square tests for categorical variables and with the use of t-tests for age as a continuous variable.

twice as likely to be in fair or poor health as the general population, all of which suggest higher mortality,³⁹ and these findings are consistent with previous expansions.⁴⁰ Furthermore, Medicaid enrollment often occurs at the point of care for patients with acute illnesses — in emergency departments, doctors' offices, and hospitals^{41,42} — when the risk of death (and benefits of coverage) may be particularly high.

Our study has several limitations. We examined three expansion states, and the results are largely driven by the largest (New York), so our results may not be generalizable to other states. Common methods for estimating standard errors are imperfect when applied to a small number of states, although our findings were robust with the use of alternative methods. The mortality data set did not allow us to control for individual-level characteristics other than race, sex, and age

(e.g., socioeconomic status or health status with respect to specific chronic diseases). We had to impute values for small subsamples after stratification according to county, race, sex, and age, although the results were robust with different imputation approaches.

Most important, our analysis is a nonrandomized design and cannot definitively show causality. Rates of insurance coverage and access to care increased in expansion states for both high-income persons and the elderly, even though the Medicaid eligibility expansions did not apply to them directly. Rates of death also declined among elderly adults, though the relative changes represented only one third of the mortality decline among adults between the ages of 20 and 64 years, leaving a significant mortality reduction among nonelderly adults that was independent of this trend. One possible explanation for these findings is that expanding coverage had positive spillover effects through increased funding to providers, particularly safety-net hospitals and clinics.⁴³ Publicity about the expansion may also have encouraged uninsured higher-income and elderly persons to obtain insurance from other sources, including those over the age of 65 years who did not meet lifetime earnings requirements for Medicare.⁴⁴

Alternatively, states may choose to expand Medicaid when their economies are thriving, and economic prosperity broadly improves coverage and access, which could produce a spurious association between eligibility expansions and health. However, our analysis of mortality was adjusted for a comprehensive list of economic measures that were specific to the county and year, and the results were not changed by these covariates. Similarly, states expanding Medicaid may simultaneously invest in public health or the health care workforce in other ways that could reduce mortality. However, we are unaware of any other contemporaneous large-scale changes in health policies in the states we studied. Moreover, the fact that mortality changes were largest in expected subpopulations offers some reassurance that we have isolated the effect of Medicaid expansions. Nonetheless, we cannot rule out other, concurrent trends that may have confounded our results.

In conclusion, our results offer new evidence that the expansion of Medicaid coverage may reduce mortality among adults, particularly those

between the ages of 35 and 64 years, minorities, and those living in poorer areas. Ongoing research on the basis of randomized data^{13,45} will be invaluable in expanding on these findings. The Medicaid program is slated to expand coverage to millions of adults in 2014 under the ACA, though the recent Supreme Court ruling enables states to choose whether they will do so, and some states may instead consider program cuts. Policymakers should be aware that major changes in

Medicaid — either expansions or reductions in coverage — may have significant effects on the health of vulnerable populations.

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Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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SPECIAL ARTICLE

The Oregon Experiment — Effects of Medicaid on Clinical Outcomes

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ABSTRACT

BACKGROUND

Despite the imminent expansion of Medicaid coverage for low-income adults, the effects of expanding coverage are unclear. The 2008 Medicaid expansion in Oregon based on lottery drawings from a waiting list provided an opportunity to evaluate these effects.

METHODS

Approximately 2 years after the lottery, we obtained data from 6387 adults who were randomly selected to be able to apply for Medicaid coverage and 5842 adults who were not selected. Measures included blood-pressure, cholesterol, and glycosylated hemoglobin levels; screening for depression; medication inventories; and self-reported diagnoses, health status, health care utilization, and out-of-pocket spending for such services. We used the random assignment in the lottery to calculate the effect of Medicaid coverage.

RESULTS

We found no significant effect of Medicaid coverage on the prevalence or diagnosis of hypertension or high cholesterol levels or on the use of medication for these conditions. Medicaid coverage significantly increased the probability of a diagnosis of diabetes and the use of diabetes medication, but we observed no significant effect on average glycosylated hemoglobin levels or on the percentage of participants with levels of 6.5% or higher. Medicaid coverage decreased the probability of a positive screening for depression (−9.15 percentage points; 95% confidence interval, −16.70 to −1.60; $P=0.02$), increased the use of many preventive services, and nearly eliminated catastrophic out-of-pocket medical expenditures.

CONCLUSIONS

This randomized, controlled study showed that Medicaid coverage generated no significant improvements in measured physical health outcomes in the first 2 years, but it did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.

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IN 2008, OREGON INITIATED A LIMITED EXPANSION of its Medicaid program for low-income adults through a lottery drawing of approximately 30,000 names from a waiting list of almost 90,000 persons. Selected adults won the opportunity to apply for Medicaid and to enroll if they met eligibility requirements. This lottery presented an opportunity to study the effects of Medicaid with the use of random assignment. Earlier, nonrandomized studies sought to investigate the effect of Medicaid on health outcomes in adults with the use of quasi-experimental approaches.^{1,2} Although these approaches can be an improvement over observational designs and often involve larger samples than are feasible with a randomized design, they cannot eliminate confounding factors as effectively as random assignment. We used the random assignment embedded in the Oregon Medicaid lottery to examine the effects of insurance coverage on health care use and health outcomes after approximately 2 years.

METHODS

RANDOMIZATION AND INTERVENTION

Oregon Health Plan Standard is a Medicaid program for low-income, uninsured, able-bodied adults who are not eligible for other public insurance in Oregon (e.g., Medicare for persons 65 years of age or older and for disabled persons; the Children's Health Insurance Program for poor children; or Medicaid for poor children, pregnant women, or other specific, categorically eligible populations). Oregon Health Plan Standard closed to new enrollment in 2004, but the state opened a new waiting list in early 2008 and then conducted eight random lottery drawings from the list between March and September of that year to allocate a limited number of spots.

Persons who were selected won the opportunity — for themselves and any household member — to apply for Oregon Health Plan Standard. To be eligible, persons had to be 19 to 64 years of age and Oregon residents who were U.S. citizens or legal immigrants; they had to be ineligible for other public insurance and uninsured for the previous 6 months, with an income that was below 100% of the federal poverty level and assets of less than \$2,000. Persons who were randomly selected in the lottery were sent an application. Those who completed it and met the eligibility criteria were enrolled in the plan. Oregon Health

Plan Standard provides comprehensive medical benefits, including prescription drugs, with no patient cost-sharing and low monthly premiums (\$0 to \$20, based on income), mostly through managed-care organizations. The lottery process and Oregon Health Plan Standard are described in more detail elsewhere.⁴

DATA COLLECTION

We used an in-person data-collection protocol to assess a wide variety of outcomes. We limited data collection to the Portland, Oregon, metropolitan area because of logistical constraints. Our study population included 20,745 people: 10,405 selected in the lottery (the lottery winners) and 10,340 not selected (the control group). We conducted interviews between September 2009 and December 2010. The interviews took place an average of 25 months after the lottery began.

Our data-collection protocol included detailed questionnaires on health care, health status, and insurance coverage; an inventory of medications; and performance of anthropometric and blood-pressure measurements. Dried blood spots were also obtained.⁵ Depression was assessed with the use of the eight-question version of the Patient Health Questionnaire (PHQ-8),⁶ and self-reported health-related quality of life was assessed with the use of the Medical Outcomes Study 8-Item Short-Form Survey.⁷ More information on recruitment and field-collection protocols are included in the study protocol (available with the full text of this article at NEJM.org); more information on specific outcome measures is provided in the Supplementary Appendix (available at NEJM.org). Multiple institutional review boards approved the study, and written informed consent was obtained from all participants.

STATISTICAL ANALYSIS

Virtually all the analyses reported here were prespecified and publicly archived (see the protocol).⁸ Prespecification was designed to minimize issues of data and specification mining and to provide a record of the full set of planned analyses. The results of a few additional post hoc analyses are also presented and are noted as such in Tables 1 through 5. Analyses were performed with the use of Stata software, version 12.⁹

Adults randomly selected in the lottery were given the option to apply for Medicaid, but not all persons selected by the lottery enrolled in

Medicaid (either because they did not apply or because they were deemed ineligible). Lottery selection increased the probability of Medicaid coverage during our study period by 24.1 percentage points (95% confidence interval [CI], 22.3 to 25.9; $P < 0.001$). The subgroup of lottery winners who ultimately enrolled in Medicaid was not comparable to the overall group of persons who did not win the lottery. We therefore used a standard instrumental-variable approach (in which lottery selection was the instrument for Medicaid coverage) to estimate the causal effect of enrollment in Medicaid. Intuitively, since the lottery increased the chance of being enrolled in Medicaid by about 25 percentage points, and we assumed that the lottery affected outcomes only by changing Medicaid enrollment, the effect of being enrolled in Medicaid was simply about 4 times (i.e., 1 divided by 0.25) as high as the effect of being able to apply for Medicaid. This yielded a causal estimate of the effect of insurance coverage.⁴⁰ (See the Supplementary Appendix for additional details.)

All analyses were adjusted for the number of household members on the lottery list because selection was random, conditional on household size. Standard errors were clustered according to household to account for intrahousehold correlation. We fitted linear probability models for binary outcomes. As sensitivity checks, we showed that our results were robust when the average marginal effects from logistic regressions for binary outcomes were estimated and when demographic characteristics were included as covariates (see the Supplementary Appendix). All analyses were weighted for the sampling and field-collection design; construction of the weights is detailed in the Supplementary Appendix.

RESULTS

STUDY POPULATION

Characteristics of the respondents are shown in Table 1. A total of 12,229 persons in the study sample responded to the survey, for an effective response rate of 73%. There were no significant differences between those selected in the lottery and those not selected with respect to the response rates to either the full survey (0.28 percentage points higher in the group selected in the lottery, $P = 0.86$) or specific survey measures, each of which had a response rate of at least 97% among people who completed any part of the survey. Just over

Table 1. Characteristics of the 12,229 Survey Respondents.*

Characteristic	Controls (N=5842)	Lottery Winners (N=6387)†	P Value
	percent		
Female sex	56.9	56.4	0.60
Age group‡			
19–34 yr	36.0	35.1	0.38
35–49 yr	36.4	36.6	0.87
50–64 yr	27.6	28.3	0.43
Race or ethnic group§			
Non-Hispanic			
White	68.8	69.2	0.68
Black	10.5	10.6	0.82
Other	14.8	14.8	0.97
Hispanic	17.2	17.0	0.82
Interview conducted in English	88.2	88.5	0.74

* Values for the control group (persons not selected in the lottery) are weighted means, and values for the lottery-winner group are regression-adjusted weighted means. P values are for two-tailed t-tests of the equality of the two means.

† Lottery winners were adults who were randomly selected in the lottery to be able to apply for Medicaid coverage.

‡ The data on age are for the age of the respondent at the time of the in-person interview. The study sample was restricted to persons who were between 19 and 64 years of age during the study period.

§ Race and ethnic group were self-reported. The categories of non-Hispanic race (white, black, and other) were not mutually exclusive; respondents could report as many races or ethnic groups as they wished.

half the participants were women, about a quarter were 50 to 64 years of age (the oldest eligible age group), and about 70% were non-Hispanic white. There were no significant differences between those selected in the lottery and those not selected with respect to these characteristics (F statistic, 0.20; $P = 0.99$) or to the wide variety of prerandomization and interview characteristics examined (see the Supplementary Appendix).

CLINICAL MEASURES AND HEALTH OUTCOMES

Table 2 shows estimated effects of Medicaid coverage on blood-pressure, total and high-density lipoprotein (HDL) cholesterol, and glycated hemoglobin levels and depression. In the control group, 30% of the survey respondents had positive screening results for depression, and we detected elevated blood pressure in 16%, a high total cholesterol level in 14%, and a glycated hemoglobin level of 6.5% or more (a diagnostic criterion for

diabetes) in 5%. Medicaid coverage did not have a significant effect on measures of blood pressure, cholesterol, or glycated hemoglobin. Further analyses involving two prespecified subgroups — persons 50 to 64 years of age and those who reported receiving a diagnosis of diabetes, hypertension, a high cholesterol level, a heart attack, or congestive heart failure before the lottery (all of which were balanced across the two study groups) — showed similar results (see the Supplementary Appendix).

The predicted 10-year risk of cardiovascular events was measured with the use of the Framingham risk score, which estimates risk among persons older than 30 years of age according to sex, age, levels of total cholesterol and HDL cholesterol, blood pressure and use or nonuse of blood-pressure medication, status with respect to diabetes, and smoking status, with the predicted risk of a cardiovascular event within 10 years ranging from less than 1% to 30%.¹¹ The

10-year predicted risk did not change significantly with Medicaid coverage (−0.21 percentage points; 95% CI, −1.56 to 1.15; P=0.76).

We investigated whether Medicaid coverage affected the diagnosis of and use of medication for hypertension, hypercholesterolemia, or diabetes. Table 2 shows diagnoses after the lottery and current medication use. We found no effect of Medicaid coverage on diagnoses after the lottery or on the use of medication for blood-pressure and high cholesterol levels. We did, however, find a greater probability of receiving a diagnosis of diabetes (3.83 percentage points; 95% CI, 1.93 to 5.73; P<0.001) and using medications for diabetes (5.43 percentage points; 95% CI, 1.39 to 9.48; P=0.008). These are substantial increases from the mean rates of diagnosis and medication use in the control group (1.1% and 6.4%, respectively).

A positive result on screening for depression was defined as a score of 10 or more on the PHQ-8 (which ranges from 0 to 24, with higher

Table 2. Mean Values and Absolute Change in Clinical Measures and Health Outcomes with Medicaid Coverage.*

Variable	Mean Value in Control Group	Change with Medicaid Coverage (95% CI)†	P Value
Blood pressure			
Systolic (mm Hg)	119.3±16.9	−0.52 (−2.97 to 1.93)	0.68
Diastolic (mm Hg)	76.0±12.1	−0.81 (−2.65 to 1.04)	0.39
Elevated (%)‡	16.3	−1.33 (−7.16 to 4.49)	0.65
Hypertension			
Diagnosis after lottery (%)§¶	5.6	1.76 (−1.89 to 5.40)	0.34
Current use of medication for hypertension (%)§§	13.9	0.66 (−4.48 to 5.80)	0.80
Cholesterol**			
Total level (mg/dl)	204.1±34.0	2.20 (−3.44 to 7.84)	0.45
High total level (%)	14.1	−2.43 (−7.75 to 2.89)	0.37
HDL level (mg/dl)	47.6±13.1	0.83 (−1.31 to 2.98)	0.45
Low HDL level (%)	28.0	−2.82 (−10.28 to 4.64)	0.46
Hypercholesterolemia			
Diagnosis after lottery (%)§¶	6.1	2.39 (−1.52 to 6.29)	0.23
Current use of medication for high cholesterol level (%)§§	8.5	3.80 (−0.75 to 8.35)	0.10
Glycated hemoglobin			
Level (%)	5.3±0.6	0.01 (−0.09 to 0.11)	0.82
Level ≥6.5% (%)††	5.1	−0.93 (−4.44 to 2.59)	0.61
Diabetes			
Diagnosis after lottery (%)§¶	1.1	3.83 (1.93 to 5.73)	<0.001
Current use of medication for diabetes (%)§§	6.4	5.43 (1.39 to 9.48)	0.008

EFFECTS OF MEDICAID ON CLINICAL OUTCOMES

Table 2 (Continued.)

Variable	Mean Value in Control Group	Change with Medicaid Coverage (95% CI) [†]	P Value
Depression			
Positive screening result (%) ^{‡‡}	30.0	-9.15 (-16.70 to -1.60)	0.02
Diagnosis after lottery (%) ^{§§}	4.8	3.81 (0.15 to 7.46)	0.04
Current use of medication for depression (%)	16.8	5.49 (-0.46 to 11.45)	0.07
Framingham risk score (%)^{§§§}			
Overall	8.2±7.5	-0.21 (-1.56 to 1.15)	0.76
High-risk diagnosis	11.6±8.3	1.63 (-1.11 to 4.37)	0.24
Age of 50-64 yr	13.9±8.2	-0.37 (-2.64 to 1.90)	0.75

* Plus-minus values are weighted means ±SD. Where means are shown without standard deviations, they are weighted means. The effect of Medicaid coverage was estimated with the use of two-stage least-squares instrumental-variable regression. All regressions include indicators for the number of household members on the lottery list, and all standard errors were "clustered," or adjusted to allow for arbitrary correction of error terms within households. For the blood-pressure measures, all regressions also included controls for age (with dummies for age decile) and sex. All analyses were weighted with the use of survey weights. The sample size was all 12,229 survey respondents for all measures except for the Framingham risk score. HDL denotes high-density lipoprotein.

† For variables measured as percentages, the change is expressed as percentage points.

‡ Elevated blood pressure was defined as a systolic pressure of 140 mm Hg or more and a diastolic pressure of 90 mm Hg or more.

§ This analysis was not prespecified.

§§ A participant was considered to have received a diagnosis of a certain condition after the lottery if he or she reported a first diagnosis after March 2008 (the start of the lottery). A participant who received a diagnosis before March 2008 was not considered to have a diagnosis after the lottery.

|| A participant was considered to have received medication for the condition if one or more of the medications recorded during the interview was classified as relevant for that condition.

** A high total cholesterol level was defined as 240 mg per deciliter (6.2 mmol per liter) or higher. A low HDL cholesterol level was defined as less than 40 mg per deciliter (1.03 mmol per liter). There was no separate measurement of low-density lipoprotein cholesterol.

†† A glycated hemoglobin level of 6.5% or higher is a diagnostic criterion for diabetes.

‡‡ A positive result on screening for depression was defined as a score of 10 or higher on the Patient Health Questionnaire 8 (PHQ-8). Scores on the PHQ-8 range from 0 to 24, with higher scores indicating more symptoms of depression.

§§§ The Framingham risk score was used to predict the 10-year cardiovascular risk. Risk scores were calculated separately for men and women on the basis of the following variables: age, total cholesterol and HDL cholesterol levels, measured blood pressure and use or nonuse of medication for high blood pressure, current smoking status, and status with respect to a glycated hemoglobin level ≥6.5%. Framingham risk scores, which are calculated for persons 30 years of age or older, range from 0.99 to 30%. Samples sizes for risk scores were 9525 participants overall, 3099 participants with high-risk diagnoses, and 3372 participants with an age of 50 to 64 years. A high-risk diagnosis was defined as a diagnosis of diabetes, hypertension, hypercholesterolemia, myocardial infarction, or congestive heart failure before the lottery (i.e., before March 2008).

scores indicating more symptoms of depression). Medicaid coverage resulted in an absolute decrease in the rate of depression of 9.15 percentage points (95% CI, -16.7 to -1.60; P=0.02), representing a relative reduction of 30%. Although there was no significant increase in the use of medication for depression, Medicaid coverage led to an absolute increase in the probability of receiving a diagnosis of depression after the lottery of 3.81 percentage points (95% CI, 0.15 to 7.46; P=0.04), representing a relative increase of about 80%.

HEALTH-RELATED QUALITY OF LIFE AND HAPPINESS

Table 3 shows the effects of Medicaid coverage on health-related quality of life and level of happiness. Medicaid coverage led to an increase in the proportion of people who reported that their health was the same or better as compared with their health 1 year previously (7.84 percentage points; 95% CI, 1.45 to 14.23; P=0.02). The physical-component and mental-component scores of the health-related quality of life measure are based on different weighted combinations of the eight-question battery; each ranges from 0 to 100,

Table 3. Mean Values and Absolute Change in Health-Related Quality of Life and Happiness with Medicaid Coverage.*

Variable	Mean Value in Control Group	Change with Medicaid Coverage (95% CI)†	P Value
Health-related quality of life			
Health same or better vs. 1 yr earlier (%)	80.4	7.84 (1.45 to 14.23)	0.02
SF-8 subscale‡			
Mental-component score	44.4±11.4	1.95 (0.03 to 3.88)	0.05
Physical-component score	45.5±10.5	1.20 (-0.54 to 2.93)	0.18
No pain or very mild pain (%)	56.4	1.16 (-6.94 to 9.26)	0.78
Very happy or pretty happy (%)	74.9	1.18 (-5.85 to 8.21)	0.74

* Plus-minus values are weighted means ±SD. Where means are shown without standard deviations, they are weighted means. The effect of Medicaid coverage was estimated with the use of two-stage least-squares instrumental-variable regression. All regressions included indicators for the number of household members on the lottery list, and all standard errors were clustered on household. All analyses were weighted with the use of survey weights. The sample was all 12,229 survey respondents.

† For variables measured as percentages, the change is expressed as percentage points.

‡ Scores on the Medical Outcomes Study 8-Item Short-Form Health Survey (SF-8) range from 0 to 100, with higher subscale scores indicating better self-reported health-related quality of life. The scale is normalized to yield a mean of 50 and a standard deviation of 10 in the general U.S. population.

with higher scores corresponding to better health-related quality of life. Medicaid coverage led to an increase of 1.95 points (95% CI, 0.03 to 3.88; $P=0.05$) in the average score on the mental component; the magnitude of improvement was approximately one fifth of the standard deviation of the mental-component score. We did not detect a significant difference in the quality of life related to physical health or in self-reported levels of pain or happiness.

FINANCIAL HARDSHIP

Table 4 shows that Medicaid coverage led to a reduction in financial strain from medical costs, according to a number of self-reported measures. In particular, catastrophic expenditures, defined as out-of-pocket medical expenses exceeding 30% of income, were nearly eliminated. These expenditures decreased by 4.48 percentage points (95% CI, -8.26 to -0.69; $P=0.02$), a relative reduction of more than 80%.

ADDITIONAL OUTCOMES

Table 5 shows the effects of Medicaid coverage on health care utilization, spending on health care, preventive care, access to and quality of care, smoking status, and obesity. Medicaid coverage resulted in an increase in the number of prescription drugs received and office visits made in the previous year; we did not find significant changes in visits to the emergency department or hos-

pital admissions. We estimated that Medicaid coverage increased annual medical spending (based on measured use of prescription drugs, office visits, visits to the emergency department, and hospital admissions) by \$1,172, or about 35% relative to the spending in the control group. Medicaid coverage also led to increases in some preventive care and screening services, including cholesterol screening (an increase of 14.57 percentage points; 95% CI, 7.09 to 22.04; $P<0.001$) and improved perceived access to care, including a usual place of care (an increase of 23.75 percentage points; 95% CI, 15.44 to 32.06; $P<0.001$). We found no significant effect of Medicaid coverage on the probability that a person was a smoker or obese.

DISCUSSION

This study was based on more than 12,000 in-person interviews conducted approximately 2 years after a lottery that randomly assigned access to Medicaid for low-income, able-bodied, uninsured adults — a group that comprises the majority of persons who are newly eligible for Medicaid under the 2014 expansion.¹² The results confirm that Medicaid coverage increased overall health care utilization, improved self-reported health, and reduced financial strain; these findings are consistent with previously published results based on mail surveys conducted approximately 1 year af-

EFFECTS OF MEDICAID ON CLINICAL OUTCOMES

Table 4. Mean Values and Absolute Change in Financial Hardship with Medicaid Coverage.*

Variable	Mean Value in Control Group	Change with Medicaid Coverage (95% CI)†	P Value
Any out-of-pocket spending (%)	58.8	-15.30 (-23.28 to -7.32)	<0.001
Amount of out-of-pocket spending (\$)	552.8±1219.5	-215.35 (-408.75 to -21.95)	0.03
Catastrophic expenditures (%)‡	5.5	-4.48 (-8.26 to -0.69)	0.02
Any medical debt (%)	56.8	-13.28 (-21.59 to -4.96)	0.002
Borrowed money to pay bills or skipped payment (%)	24.4	-14.22 (-21.02 to -7.43)	<0.001

* Plus-minus values are weighted means \pm SD. Where means are shown without standard deviations, they are weighted means. The effect of Medicaid coverage was estimated with the use of two-stage least-squares instrumental-variable regression. All regressions include indicators for the number of household members on the lottery list, and all standard errors were clustered on household. All analyses were weighted with the use of survey weights. The sample was all 12,229 survey respondents.

† For variables measured as percentages, the change is expressed as percentage points.

‡ Persons with catastrophic expenditures had out-of-pocket medical expenses that exceeded 30% of their household income.

ter the lottery.⁴ With these new data, we found that increased health care utilization observed at 1 year persisted, and we present new results on the effects of Medicaid coverage on objectively measured physical health, depression, condition-specific treatments, and other outcomes of interest.

Medicaid coverage had no significant effect on the prevalence or diagnosis of hypertension or high cholesterol levels or on the use of medication for these conditions. It increased the probability of a diagnosis of diabetes and the use of medication for diabetes, but it had no significant effect on the prevalence of measured glycated hemoglobin levels of 6.5% or higher. Medicaid coverage led to a substantial reduction in the risk of a positive screening result for depression. This pattern of findings with respect to clinically measured health — an improvement in mental health but not in physical health (Table 2) — was mirrored in the self-reported health measures, with improvements concentrated in mental rather than physical health (Table 3). The improvements appear to be specific to depression and mental health measures; Medicaid coverage did not appear to lead to an increase in self-reported happiness, which is arguably a more general measure of overall subjective well-being.

Hypertension, high cholesterol levels, diabetes, and depression are only a subgroup of the set of health outcomes potentially affected by Medicaid coverage. We chose these conditions because they are important contributors to morbidity and mortality, feasible to measure, prevalent in the low-income population in our study, and plausibly modifiable by effective treatment within a

2-year time frame.¹³⁻¹⁶ Nonetheless, our power to detect changes in health was limited by the relatively small numbers of patients with these conditions; indeed, the only condition in which we detected improvements was depression, which was by far the most prevalent of the four conditions examined. The 95% confidence intervals for many of the estimates of effects on individual physical health measures were wide enough to include changes that would be considered clinically significant — such as a 7.16-percentage-point reduction in the prevalence of hypertension. Moreover, although we did not find a significant change in glycated hemoglobin levels, the point estimate of the decrease we observed is consistent with that which would be expected on the basis of our estimated increase in the use of medication for diabetes. The clinical-trial literature indicates that the use of oral medication for diabetes reduces the glycated hemoglobin level by an average of 1 percentage point within as short a time as 6 months.¹⁵ This estimate from the clinical literature suggests that the 5.4-percentage-point increase in the use of medication for diabetes in our cohort would decrease the average glycated hemoglobin level in the study population by 0.05 percentage points, which is well within our 95% confidence interval. Beyond issues of power, the effects of Medicaid coverage may be limited by the multiple sources of slippage in the connection between insurance coverage and observable improvements in our health metrics; these potential sources of slippage include access to care, diagnosis of underlying conditions, prescription of appropriate med-

Table 8. Mean Values and Absolute Change in Health Care Utilization and Spending, Preventive Care, Access to and Quality of Care, and Smoking and Obesity with Medicaid Coverage.*

Variable	Mean Value in Control Group	Change with Medicaid Coverage (95% CI)†	P Value
Utilization (no. of visits or medications)			
Current prescription drugs	1.8±2.8	0.66 (0.21 to 1.11)	0.004
Office visits in past 12 mo	5.5±11.6	2.70 (0.91 to 4.49)	0.003
Outpatient surgery in past 12 mo	0.1±0.4	0.03 (-0.03 to 0.09)	0.28
Emergency department visits in past 12 mo	1.0±2.0	0.09 (-0.23 to 0.42)	0.57
Hospital admissions in past 12 mo	0.2±0.6	0.07 (-0.03 to 0.17)	0.17
Estimate of annual health care spending (\$)‡	3,257.3	1,171.63 (199.35 to 2,143.91)	0.018
Preventive care in past 12 mo (%)			
Cholesterol-level screening	27.2	14.57 (7.09 to 22.04)	<0.001
Fecal occult-blood test in persons ≥50 yr	19.1	1.26 (-9.44 to 11.96)	0.82
Colonoscopy in persons ≥50 yr	10.4	4.19 (-4.25 to 12.62)	0.33
Flu shot in persons ≥50 yr	35.5	-5.74 (-19.31 to 7.83)	0.41
Papanicolaou smear in women	44.9	14.44 (2.64 to 26.24)	0.016
Mammography in women ≥50 yr	28.9	29.67 (11.96 to 47.37)	0.001
PSA test in men ≥50 yr	21.4	19.18 (1.14 to 37.21)	0.037
Perceived access to and quality of care (%)			
Had a usual place of care	46.1	23.75 (15.44 to 32.06)	<0.001
Received all needed care in past 12 mo	61.0	11.43 (3.62 to 19.24)	0.004
Care was of high quality, if received, in past 12 mo	78.4	9.85 (2.71 to 17.00)	0.007
Smoking status and obesity (%)			
Current smoker	42.8	5.58 (-2.54 to 13.70)	0.18
Obese	41.5	0.39 (-7.89 to 8.67)	0.93

* Plus-minus values are weighted means ±SD. Where means are shown without standard deviations, they are weighted means. The effect of Medicaid coverage was estimated with the use of two-stage least-squares instrumental-variable regression. All regressions include indicators for the number of household members on the lottery list, and all standard errors were clustered on household. All analyses were weighted with the use of survey weights. The sample size was all 12,229 survey respondents. For some prevention measures, the sample was limited to the 3374 survey respondents who were at least 50 years of age, the 1864 female survey respondents who were at least 50 years of age, or the 1509 male survey respondents who were at least 50 years of age. The sample for quality of care was limited to the 9694 survey respondents who received care in the previous 12 months. PSA denotes prostate-specific antigen.

† For variables measured as percentages, the change is expressed as percentage points.

‡ Annual spending was calculated by multiplying the numbers of prescription drugs, office visits, visits to the emergency department, and hospital admissions by the estimated cost of each. See the Supplementary Appendix for details.

ications, compliance with recommendations, and effectiveness of treatment in improving health.²⁷

Anticipating limitations in statistical power, we prespecified analyses of subgroups in which effects might be stronger, including the near-elderly and persons who reported having received a diagnosis of diabetes, hypertension, a high cholesterol level, a heart attack, or congestive heart failure before the lottery. We did not find significant changes in any of these subgroups. To try to improve statistical power, we used the

Framingham risk score as a summary measure. This allowed us to reject a decrease of more than 20% in the predicted 10-year cardiovascular risk or a decrease of more than 10% in predicted risk among the participants with high-risk diagnoses before the lottery. Our results were thus consistent with at best limited improvements in these particular dimensions of physical health over this time period, in contrast with the substantial improvement in mental health.

Although changes in health status are of great

interest, they are not the only important potential benefit of expanded health insurance coverage. Health insurance is a financial product that is aimed at providing financial security by protecting people from catastrophic health care expenses if they become injured or sick (and ensuring that the providers who see them are paid). In our study, Medicaid coverage almost completely eliminated catastrophic out-of-pocket medical expenditures.

Our estimates of the effect of Medicaid coverage on health, health care utilization, and financial strain apply to able-bodied, uninsured adults with incomes below 100% of the federal poverty level who express interest in insurance coverage — a population of considerable interest for health care policy, given the planned expansion of Medicaid. The Patient Protection and Affordable Care Act of 2010 allows states to extend Medicaid eligibility to all adults with incomes of up to 138% of the federal poverty level. However, there are several important limits to the generalizability of our findings. First, the low-income uninsured population in Oregon differs from the overall population in the United States in some respects, such as the proportions of persons who are members of racial and ethnic minority groups. Second, our estimates speak to the effect of Medicaid coverage on the subgroup of people who signed up for the lottery and for whom winning the lottery affected their coverage status; in the Supplementary Appendix we provide some additional details on the characteristics of this group. Medicaid coverage may have different effects for persons who seek insurance through the lottery than for the general population affected by coverage mandates. For example, persons who signed up for the lottery may have expected a greater health benefit from insurance coverage than those who did not sign up. Of course, most estimates suggest imperfect (and selective) Medicaid take-up rates even under man-

dates.¹⁸ Third, the newly insured participants in our study constituted a small share of all uninsured Oregon residents, limiting the system-level effects that insuring them might generate, such as strains on provider capacity or investment in infrastructure. Fourth, we examined outcomes in people who gained an average of 17 months of coverage (those insured through the lottery were not necessarily covered for the entire study period); the effects of insurance in the longer run may differ.

Despite these limitations, our study provides evidence of the effects of expanding Medicaid to low-income adults on the basis of a randomized design, which is rarely available in the evaluation of social insurance programs. We found that insurance led to increased access to and utilization of health care, substantial improvements in mental health, and reductions in financial strain, but we did not observe reductions in measured blood-pressure, cholesterol, or glycated hemoglobin levels.

The findings and conclusions expressed in this article are solely those of the authors and do not necessarily represent the views of the funders.

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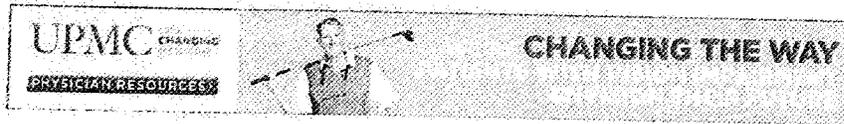
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Viewpoint | February 22/29, 2012

Veterans and the Affordable Care Act

Kenneth W. Kizer, MD, MPH

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Armed conflict has been a frequent occurrence throughout US history. During the last century, the United States has fought 8 wars that together span more than 35 years, not counting numerous conflicts that are not officially considered wars. In view of the many health consequences of war, the potential effect of the Affordable Care Act (ACA) on health care for veterans warrants careful consideration.

In 2011, there were 22.2 million veterans of service in the US Armed Forces. Veterans are a highly diverse population but can be grouped into 3 categories from a health insurance perspective. Approximately 37% are enrolled in the Department of Veterans Affairs (VA) health care system in accordance with a congressionally mandated eligibility system based on having a service-connected disability, low income and net worth, or other prescribed circumstances. More than 80% of VA enrollees older than 65 years are also covered by Medicare and about 25% of enrollees are beneficiaries of 2 or more non-VA federal health plans (eg, Medicare, Medicaid, TRICARE, or Indian Health Service). Another 56% of veterans have private health insurance or are covered by a non-VA federal health plan, while 7% have no health insurance. These latter veterans are poor or near poor but have incomes or net worth that exceed the mean test thresholds for VA health care eligibility.¹

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Northeast Ohio Medicaid Expansion Coalition

Medicaid Expansion: Reduce Uninsured and Provide Coverage to Ohio Veterans

Thousands of Ohio veterans—and their families—could gain health insurance and improve their health and well-being if the state makes the right decision to move forward with the Medicaid expansion now under consideration in Columbus.

Despite having put their health and lives at risk while serving in the armed forces, 1.3 million U.S. veterans—including 52,000 in Ohio—lack health insurance. Nationally, almost half of these veterans would qualify for coverage if all states expand Medicaid eligibility, a proposal currently included in the Kasich Administration's FY 2014-2015 budget proposal as a result of options provided for in the Affordable Care Act. Close to 26,000 Ohio veterans without insurance could qualify for Medicaid coverage if the state expands. Their spouses could gain needed coverage as well.

Category	Number	Newly Qualified for Medicaid*
Uninsured Veterans	52,000	48.8%
Uninsured Family Members of Veterans	35,000	35.5%
Veterans w/ VA Coverage Alone	37,000	51.9%

Most people believe that veterans can receive health care through the US Department of Veterans Affairs (VA), however that is not the case. Only about 37 percent of the country's more than 22 million veterans receive health coverage through the VA. Not all veterans can receive these benefits. Eligibility is determined by active duty status, condition of discharge, length of service, income level and other factors. Only in limited circumstances are veterans' spouses and families able to access VA health care.

Veterans without health insurance often have medical problems, many of which go untreated:

- One in three uninsured veterans report having at least one chronic health condition.
- Roughly 15 percent report being in only fair or poor health.
- More than 15 percent face significant physical, mental or emotional problems.
- Over 40 percent report having unmet medical needs.
- Roughly one third of uninsured veterans have delayed seeking needed health care due to cost.

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Uninsured Veterans and Family Members: State and National Estimates of Expanded Medicaid Eligibility Under the ACA

Timely Analysis of Immediate Health Policy Issues

March 2013

Jennifer Hills and Corbin Lewis McKinney

Summary

Analysis of the 2008–2010 American Community Survey (ACS) indicates that 535,000 uninsured veterans and 174,000 uninsured spouses of veterans—or four in 10 uninsured veterans and one in four uninsured spouses—have incomes below 138 percent of the federal poverty level (FPL) and could qualify for Medicaid or new subsidies for coverage under the Affordable Care Act (ACA). Most of these uninsured—414,000 veterans and 113,000 spouses—have incomes below 100 percent of FPL, and will therefore only have new coverage options under the ACA

if their state expands Medicaid. However, fewer than half live in states in which the governor supports their state participating in the expansion, while the majority live in states that have chosen not to expand Medicaid or have not yet decided whether to expand. The extent to which uninsured veterans and their family members with incomes below the FPL will have access to new coverage options under the ACA will depend on whether they live in a state that adopts the Medicaid expansion.

Introduction

The ACA of 2010 includes a Medicaid expansion, new health insurance exchanges and subsidies for coverage, and an individual mandate, all of which are designed to reduce the number of individuals who lack health insurance coverage. According to estimates from the Congressional Budget Office, full implementation of the ACA, including the Medicaid expansion, would cut in half the number of uninsured in the nation.¹ At this point, however, it is not clear how many states will choose to expand Medicaid, which became a state option in June 2012. While governors in 25 states so far have said they support their state participating in the expansion, 14 have indicated they oppose participating, and the remaining have not made a firm commitment one way or the other.²

A number of studies have examined the cost and coverage implications of state decisions to adopt the ACA Medicaid expansion.³ In this brief, we examine the number of uninsured veterans and family members nationwide, and assess—both nationally and in each state—how many uninsured veterans and their spouses could gain Medicaid coverage under the ACA. This analysis builds on our prior research, which found that over a million nonelderly

veterans—or one in 10 veterans under age 65—and nearly a million of their family members lacked health insurance coverage nationwide.⁴

Veterans often have distinct health care needs and health insurance options. While health care through the Department of Veterans Affairs (VA) is available to many veterans, priority and access are based on service-related disabilities, income level, and other factors.⁵ This means that many low-income veterans are eligible for VA health care, but lack of proximity to VA facilities or lack of knowledge that VA care is available could keep some eligible veterans from enrolling. While the VA provides health care for certain eligible beneficiaries of veterans, VA care is not an option for other uninsured family members of veterans.⁶ Coverage through Medicaid or the Children's Health Insurance Program (CHIP) is currently available to some veterans and family members who have low incomes, but Medicaid eligibility for adults is quite limited in most states: the median income eligibility level for parents is just 61 percent of FPL, and only nine states offer comprehensive Medicaid coverage to nondisabled, non-pregnant adults without dependent children.⁷ Under the ACA, Medicaid

eligibility for adults would be expanded to 138 percent of FPL (\$15,415 for an individual, \$26,344 for a family of three in 2012), which represents a substantial eligibility expansion in most states.

While the Medicaid expansion and other coverage provisions in the ACA were not designed specifically to target uninsured veterans or their families and would not change the VA's health care system,⁸ they offer new coverage options to veterans and their families.⁹ In states not expanding Medicaid, those with incomes of 100 to 138 percent of FPL could qualify for exchange subsidies if they do not have access to affordable employer-sponsored insurance (ESI), but individuals with incomes below 100 percent of FPL would not be eligible for subsidies for exchange coverage.¹⁰

In our prior research, we found that nearly half of uninsured veterans and about a third of their family members had incomes below 138 percent of FPL, and thus would be eligible for Medicaid coverage under the ACA if their state were to expand.¹¹ In this brief, we present updated national estimates of the number of uninsured veterans and family members in various income groups, and examine the number of veterans and

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their spouses in each state who could enroll in Medicaid under the ACA.

Data and Methods

Data Source. These estimates are derived from the ACS, an annual survey fielded by the U.S. Census Bureau.¹² The ACS includes a sample from each county in the nation and uses a mixed-mode approach to achieve a response rate of 98 percent.¹³ We combine the 2008, 2009, and 2010 samples for a total of approximately 35,000 uninsured veterans and 29,000 uninsured family members.

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. Nonelderly spouses of veterans are those ages 19 to 64 who are not veterans, but who live in a household with a 19- to 64-year-old veteran who is their spouse; children of veterans are those age 18 or younger who live in a household with a 19- to 64-year-old veteran who is their biological parent, adoptive parent, or stepparent.¹⁴

Identification of Insurance Status.

Respondents identified coverage of each individual in their households by the following types of health insurance or health 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 or 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; and
- h. Any other type of health insurance or health coverage plan (respondents are asked to specify).

Multiple types of coverage can be identified for each person, and people identified as not having coverage under categories a through f (or recoded to another category from the write-in option, category h) are considered uninsured.¹⁵ Thus, we classify veterans as uninsured if they report neither using VA services nor having comprehensive health insurance coverage. Although some uninsured veterans could qualify for VA health services, the available data do not indicate how many uninsured veterans could enroll in the VA health care system or live near a VA health care facility, nor why they do not report using VA care. Following prior research, veterans reporting only VA coverage are considered insured.¹⁶ (Although veterans enrolled in VA health care receive services through the Veterans Health Administration, we refer to this as VA coverage to remain consistent with the term used in the ACS questionnaire.)

Identification of Income Groups. Income is categorized based on how it will be calculated under the ACA, defined as the ratio of modified adjusted gross income (MAGI) relative to the poverty guidelines. We examine three income groups based on their potential eligibility for Medicaid or other subsidized coverage under the ACA: (1) those below 100 percent of FPL who would be eligible for Medicaid coverage under the ACA if their state expands Medicaid, but would not be eligible for exchange subsidies if their state does not participate in the expansion; (2) those between 100 percent and 138 percent of FPL, who would also be eligible for Medicaid coverage under the ACA if their state expands, but who would be eligible for exchange subsidies if their state does not expand Medicaid, and they do not have access to affordable ESI; and (3) those above 138 percent of FPL.¹⁷

State Medicaid Expansion Status. In addition to presenting estimates of uninsured veterans and their spouses in each state, we categorize states into three groups according to their governors' stated plan as of February 26, 2013, to expand Medicaid in 2014: (1) the 25 states whose governors have announced they support participating in the Medicaid expansion, (2) the 14 states whose governors have announced they oppose participating in

the Medicaid expansion, and (3) the 12 states whose governors have not made a firm commitment.¹⁸

Additional Analyses. We also present findings on access to care differences between uninsured and insured veterans and family members of all income groups using another data source, the 2009 and 2010 National Health Interview Survey (NHIS). Details on these measures are available in a prior report.¹⁹

Results

Number of Uninsured Veterans and Family Members. Table 1 presents the number of uninsured veterans and family members overall and by income group. Nationally, there are 1.3 million uninsured nonelderly veterans. While veterans are less likely to be uninsured than the population as a whole, approximately one in 10 veterans in the nation lacks coverage (data not shown).²⁰ Nearly one-third of these uninsured veterans, or 414,000, have incomes below 100 percent of FPL, another 121,000 are between 100 percent and 138 percent of FPL, and the remainder are above 138 percent of FPL. Therefore, more than four in 10—or an estimated 535,000 uninsured veterans—have incomes below 138 percent of FPL and could be eligible for Medicaid under the ACA if their state participates in the Medicaid expansion. This is in line with estimates for the population as a whole, which indicate that almost half of all nonelderly uninsured have incomes below 138 percent of FPL and could qualify for Medicaid under the ACA.²¹ The Medicaid expansion constitutes a substantial increase in Medicaid eligibility for uninsured veterans since only an estimated one in 10 uninsured veterans could qualify for Medicaid under current eligibility rules (data not shown).²² Of the half-million uninsured veterans who would be potentially Medicaid eligible under the ACA, three-quarters have incomes below 100 percent of FPL and would not qualify for exchange subsidies if their state does not expand Medicaid.

Of the 645,000 uninsured spouses of veterans, 113,000 are below the FPL and another 61,000 have incomes between 100 percent and 138 percent of FPL, indicating

Table 1: Number of Uninsured Veterans and Family Members, by Income Group, 2008–2010

	Total (1,000's)	Below 100% FPL (1,000's)	100–138% FPL (1,000's)	Above 138% FPL (1,000's)
Veterans	1,311.5	414.2	120.8	776.4
Spouses of Veterans	645.1	112.8	61.3	471.3
Children of Veterans	318.0	49.2	28.7	240.1
Veterans and Their Family Members Combined	2,274.6	576.0	210.8	1,487.8

Notes: Nonelderly spouses of veterans are those ages 19 to 64 who are not veterans but who live in a household with a 19- to 64-year-old veteran who is their spouse. Children of veterans are those age 18 or younger who live in a household with a 19- to 64-year-old veteran who is their biological, adoptive, or stepparent.

Source: Based on 2008–2010 American Community Survey data from the Integrated Public Use Microdata Series. Estimates reflect additional Urban Institute adjustments to coverage status.

that more than one-quarter could qualify for expanded Medicaid under the ACA—much higher than the estimated 9 percent who are eligible under current rules (data not shown). Two-thirds of veterans' spouses who could qualify for expanded Medicaid under the ACA would not be eligible for exchange subsidies should their state not expand Medicaid, and since most spouses of veterans likely do not qualify for VA coverage, most would not have other public or newly subsidized coverage options.

An additional 318,000 children of veterans are uninsured. Because Medicaid/CHIP eligibility for children is more expansive than it is for adults, a much larger share of these children are currently eligible, and their eligibility is not dependent on states' decisions regarding the Medicaid expansion under the ACA.²³

Variation Across States and State Groupings. Table 2 presents estimates of veterans in these income groups across states. Seven states (California, Florida, Georgia, Michigan, North Carolina, Ohio, and Texas) are home to 43 percent of all poor uninsured veterans, or more than 175,000 uninsured veterans. Each of these states has more than 15,000 poor uninsured veterans; California, Florida, and Texas each have more than 30,000 uninsured veterans with incomes in this range. An additional 51,000 veterans between 100 percent and 138 percent of FPL live in these seven states.

When we categorize states according to their governors' support for, or opposition to, the ACA Medicaid expansion, we find that 196,000 uninsured veterans below 100 percent of FPL are in one of the 25 states whose governors have committed to expanding Medicaid, while 144,000 are

in one of the 14 states committed to not expanding Medicaid, and 74,000 are in one of the 12 states that are undecided. All together, an estimated 218,000 uninsured veterans with incomes below 100 percent of the FPL—or 53 percent of the nation's poor uninsured veterans—are in states that may not expand their Medicaid programs, and thus would not qualify for any new subsidies for coverage under the ACA if their states choose not to expand Medicaid. An additional 66,000 veterans with incomes between 100 percent and 138 percent of FPL in states in which the governor opposes the expansion or are undecided could qualify for Medicaid if their states choose to expand, but would only have access to exchange subsidies in the absence of an expansion.

Uninsured Spouses of Veterans. As with the veterans themselves, uninsured spouses of veterans in these income groups are concentrated in certain large states (Table 3). In addition, of the 113,000 poor uninsured spouses of veterans, 64,000 are in states whose administrations oppose participating in the Medicaid expansion or are undecided about whether to participate, and an additional 35,000 with incomes between 100 percent and 138 percent of FPL are in these states.²⁴ Thus, a majority of veterans' spouses who could qualify for expanded Medicaid coverage under the ACA live in states that may not expand, and, as is the case for the uninsured population as a whole,²⁵ most of these are below 100 percent of FPL and therefore would have no new coverage options under the ACA if their states do not expand.

Access to Care. According to the 2009 and 2010 NHIS, uninsurance among veterans and their family members at all

income levels is associated with greater problems accessing health care (Table 4). For instance, among uninsured veterans, 41.2 percent reported they had unmet health needs in the prior year, compared with just 12.7 percent of insured veterans. One-third of uninsured veterans (33.7 percent) had delayed care due to cost, compared with just 8.4 percent of insured veterans. The same patterns held true for veterans' uninsured family members, with 54.8 percent reporting unmet needs, and 44.1 percent delaying care due to cost—significantly higher than among insured family members of veterans.

Discussion

Nationally, an estimated 535,000 uninsured veterans have incomes below 138 percent of FPL and could qualify for coverage under the ACA if their state expands Medicaid. Three-quarters of these—over 400,000—have incomes below 100 percent of FPL and would not be eligible for new exchange subsidies; that group will qualify for new coverage options under the ACA only if their state expands Medicaid. However, over half of these uninsured veterans live in states in which the governors have indicated that they are not intending to expand Medicaid in 2014 or are undecided about whether to expand. If all states were to expand Medicaid under the ACA, four in 10 uninsured veterans and one in four uninsured spouses of veterans could gain Medicaid coverage.

Beyond the Medicaid expansion, the health insurance coverage and health care access of veterans will likely be affected by other policy changes in the coming years. In particular, the implementation of other ACA provisions—such as the “no

Table 2: Number of Uninsured Veterans (19-64), by Income Group, State, and ACA Medicaid Expansion Group, 2008-2010

	Total (1,000's)	Below 100% FPL (1,000's)	100-139% FPL (1,000's)	Above 139% FPL (1,000's)
United States	1,311.61	414.2	120.8	776.6
Support Medicaid Expansion	617.6	165.3	64.4	368.0
Arizona	29.6	8.7	2.0	18.9
Arkansas	20.3	6.1	2.4	11.8
California	106.8	37.0	8.8	60.9
Colorado	25.5	7.5	2.0	16.0
Connecticut	7.3	2.3	0.3 #	4.7
Delaware	3.5	0.7	0.5	2.3
District of Columbia	1.6	0.8	0.1 #	0.7 #
Florida	103.7	32.3	8.9	62.5
Hawaii	3.6	1.6	0.3 #	1.7
Illinois	41.9	14.4	3.2	24.3
Maryland	17.7	5.8	1.1	10.8
Massachusetts	7.8	2.2	0.4 #	5.2
Michigan	44.1	15.3	4.8	24.1
Minnesota	15.5	4.5	0.9	10.1
Missouri	30.9	9.3	3.5	18.2
Montana	9.2	3.4	0.6 #	5.2
Nevada	15.9	4.5	1.5	9.9
New Hampshire	6.2	1.0	0.5 #	4.7
New Jersey	19.2	5.8	1.5	11.9
New Mexico	12.6	4.1	1.1	7.4
North Dakota	1.7	0.4 #	0.3 #	1.0
Ohio	51.6	18.4	6.2	27.1
Rhode Island	3.4	0.8	0.3 #	2.3
Vermont	1.8	0.2 #	0.2 #	1.3
Washington	36.1	9.3	2.9	23.9
Oppose Medicaid Expansion	457.8	144.5	42.8	270.5
Alabama	26.8	10.6	2.4	13.8
Georgia	56.3	20.4	4.5	31.4
Idaho	10.0	3.0	0.8	6.2
Iowa	10.1	3.2	0.6	6.3
Louisiana	26.2	7.4	2.5	16.3
Maine	7.6	1.8	0.9	4.9
Mississippi	16.2	5.9	1.2	8.0
North Carolina	52.7	17.4	5.9	29.5
Oklahoma	26.4	7.4	2.6	16.5
Pennsylvania	45.5	14.7	4.4	26.4
South Carolina	28.9	9.8	3.2	15.9
South Dakota	4.1	1.1	0.5 #	2.6
Texas	190.3	36.6	12.3	81.4
Wisconsin	16.7	5.2	1.2	10.3
Undecided	236.1	79.5	23.6	133.0
Alaska	6.4	1.6	0.6 #	4.1
Indiana	31.0	10.2	3.5	17.3
Kansas	14.4	4.6	1.1	8.8
Kentucky	20.8	7.4	2.1	11.1
Nebraska	6.5	1.6	0.5 #	4.5
New York	36.3	10.8	3.6	23.9
Oregon	26.0	8.2	2.6	15.1
Tennessee	35.3	11.8	3.9	19.6
Utah	9.6	3.2	0.6	6.0
Virginia	32.1	9.6	2.7	19.8
West Virginia	11.3	3.5	1.8	6.0
Wyoming	4.2	0.6 #	0.6 #	2.9

Notes: # indicates the standard error is greater than 30 percent of the estimate and should be interpreted with caution. ACA Medicaid expansion groups are derived from The Advisory Board Company (Feb. 26, 2013) and indicate governors' stated positions on participation in the ACA Medicaid expansion.

Source: Based on 2008-2010 American Community Survey data from the Integrated Public Use Microdata Series. Estimates reflect additional Urban Institute adjustments to coverage status.

Table 3: Number of Uninsured Spouses of Veterans (19-64), by Income Group, State, and ACA Medicaid Expansion Group, 2008-2010

	Total (1,000's)	Below 100% FPL (1,000's)	100-138% FPL (1,000's)	Above 138% FPL (1,000's)
United States	645.1	112.5	81.3	471.3
Support Medicaid Expansion	287.8	49.0	26.0	212.8
Arizona	13.7	2.2	1.3	10.2
Arkansas	12.7	2.7	1.8	8.2
California	47.5	8.9	3.2	35.4
Colorado	12.2	2.3	1.1	8.7
Connecticut	2.7	0.5 #	0.2 #	2.0
Delaware	1.6	0.2 #	0.1 #	1.4
District of Columbia	0.1 #	0.0	0.0	0.1 #
Florida	81.7	6.9	4.5	38.3
Hawaii	1.5	0.4 #	0.1 #	1.0
Illinois	17.9	3.0	1.4	13.5
Maryland	5.7	0.6	0.2 #	4.8
Massachusetts	1.9	0.3 #	0.1 #	1.5
Michigan	19.9	3.7	2.0	14.2
Minnesota	8.0	0.9	0.5 #	6.6
Missouri	17.0	3.2	1.7	12.2
Montana	4.5	0.8	0.4	3.2
Nevada	7.8	1.2	0.6	6.0
New Hampshire	4.1	0.3 #	0.5 #	3.2
New Jersey	7.6	0.8	0.6	6.2
New Mexico	5.2	0.8	0.5 #	3.8
North Dakota	0.9	0.0 #	0.1 #	0.7
Ohio	24.0	3.8	3.3	16.8
Rhode Island	1.4	0.3 #	0.1 #	1.0
Vermont	1.1	0.0 #	0.1 #	1.0
Washington	16.9	2.9	1.4	12.6
Oppose Medicaid Expansion	242.4	41.7	23.6	177.1
Alabama	13.5	3.2	1.7	8.6
Georgia	27.5	4.3	2.8	20.3
Idaho	5.8	1.2	0.4 #	4.3
Iowa	4.6	0.5	0.5	3.6
Louisiana	13.7	2.4	1.6	9.7
Maine	3.2	0.5 #	0.5	2.2
Mississippi	9.9	2.3	1.0	6.6
North Carolina	29.1	5.1	3.3	20.7
Oklahoma	15.7	2.6	1.6	11.4
Pennsylvania	19.7	3.2	1.6	14.9
South Carolina	15.0	3.1	1.8	10.1
South Dakota	2.4	0.6 #	0.2 #	1.6
Texas	73.4	11.5	6.1	55.8
Wisconsin	8.9	1.3	0.5	7.1
Undecided	115.0	21.8	11.7	81.4
Alaska	3.1	0.4 #	0.2 #	2.6
Indiana	15.3	3.1	1.8	10.4
Kansas	6.7	1.2	0.5	5.0
Kentucky	13.3	3.3	2.0	8.1
Nebraska	3.6	0.4 #	0.4 #	2.8
New York	14.9	1.9	1.1	11.9
Oregon	12.4	2.7	1.3	8.4
Tennessee	18.6	3.6	1.6	11.3
Utah	5.1	0.8	0.2 #	4.1
Virginia	14.9	2.7	1.4	10.8
West Virginia	7.2	1.5	1.1	4.6
Wyoming	1.9	0.3 #	0.2 #	1.5

Notes: Nonelderly spouses of veterans are those ages 19 to 64 who are not veterans but who live in a household with a 19- to 64-year-old veteran who is their spouse. # indicates the standard error is greater than 30 percent of the estimate and should be interpreted with caution. ACA Medicaid expansion groups are derived from The Advisory Board Company (Feb. 26, 2013) and indicate governors' stated positions on participation in the ACA Medicaid expansion.

Source: Based on 2008-2010 American Community Survey data from the Integrated Public Use Microdata Series. Estimates reflect additional Urban Institute adjustments to coverage status.

Table 4: Unmet and Delayed Medical Needs, Nonelderly Veterans and Veterans' Nonelderly Family Members, by Insurance Status, 2009–2010

	Veterans		Family Members of Veterans	
	Uninsured	Insured	Uninsured	Insured
Any Unmet (Nonfatal) Health Needs	41.2% **	12.7%	54.6% **	12.3%
Delayed Care due to Cost	33.7% **	8.4%	44.1% **	7.6%

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 0.01 level.

wrong door” policy, whereby applications to Medicaid, CHIP, or exchange coverage can be screened for a variety of health insurance programs; the individual mandate; and the use of trained navigators to assist individuals who are seeking health insurance coverage—could affect veterans’ enrollment in VA services by increasing their awareness of and interest in VA services and making it easier to enroll.²⁶ The inclusion of screening questions about veteran status on Medicaid/exchange applications and the use of data matches to identify and enroll eligible veterans could increase take-up of coverage among veterans.²⁷ It remains to be seen the extent to which uninsured veterans would seek coverage through Medicaid, the VA, or other options under the ACA, and whether and how this will vary across states.

It is possible that some veterans now enrolled in VA care will also enroll in Medicaid and use care through Medicaid in addition to or instead of VA providers.²⁸ It is common for VA users to have other sources of coverage,²⁹ and while concerns have been raised about care coordination and continuity of care for veterans with dual coverage,³⁰ having both Medicaid and VA care could promote greater provider choice and convenience for veterans. Participation in Medicaid could increase access to care, particularly for those in more remote areas without a VA facility nearby. At the same time, being in the VA system could connect veterans with other benefits, such as job placement services, educational assistance, and housing assistance, and increase the likelihood that

their care meets their particular needs, particularly related to mental and behavioral health services. The VA is currently exploring how to help veterans successfully navigate the changing health care landscape under the ACA.³¹ Given the uncertainty around how demand for VA services could change under the ACA and the likelihood that the share of veterans with dual coverage might grow, it will be important to assess the extent to which VA provider supply meets the demand for care, and to implement efforts to reduce fragmentation of care among veterans enrolled in both VA and other coverage, such as electronic medical records sharing.³²

VA care is not an option for most uninsured family members of veterans. Enrollment in Medicaid and CHIP is expected to increase under the ACA for those who are already eligible for coverage. This could address coverage gaps for some family members, particularly among uninsured children, most of whom qualify for Medicaid or CHIP under current law. However, uninsured spouses will not have new public coverage options in those states that choose not to expand. For these uninsured, particularly for those with incomes below 100 percent of FPL, access to affordable health insurance will depend critically upon state implementation of the Medicaid expansion.³³ An additional complication for some veterans is the fact that VA care only covers the veteran, and not additional family members, which may be an issue for some families who prefer having coverage that includes all family members.

Those with family incomes between 100 percent and 138 percent of FPL in states without a Medicaid expansion, as well as some of those with incomes above 138 percent of FPL, could qualify for subsidies for coverage in new health insurance exchanges. However, eligibility would be conditional on not having access to affordable ESI, which is defined as having an offer of coverage for the worker that costs less than 9.5 percent of family income, even if the cost of family coverage is higher. Thus, even among veterans and their family members who could qualify for subsidized coverage, some could remain uninsured if they cannot afford the available ESI for themselves or their families. In addition, exchange coverage is likely to have higher premiums, deductibles, and out-of-pocket cost-sharing than would be required under Medicaid.

While the ACA provides an opportunity for states to dramatically reduce uninsurance among veterans and other uninsured adults with incomes below 138 percent of FPL by expanding Medicaid, states are also considering a number of other issues as they debate whether to expand.³⁴ This analysis suggests that, as is the case for the rest of the nonelderly uninsured, the Medicaid expansion could help address coverage gaps for veterans and their family members in many states. As with the general population, uninsurance among veterans and their family members is related to greater problems accessing care,³⁵ suggesting that increased enrollment in Medicaid would increase the likelihood that their health care needs are being met.

Endnotes

- ¹ *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*. Washington: Congressional Budget Office, 2012. http://www.cbo.gov/ftpdocs/117xx/doc11729/07-29-2012_CoverageEstimates.pdf
- ² *Where Each State Stands on ACA's Medicaid Expansion*. Washington: Advisory Board Company, 2013. <http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap> (updated February 26, 2013). In this analysis, DC is counted as a state. Although we are classifying states according to their governors' stated plans, it is possible that some states' decisions could change or that their legislatures could reach a different decision.
- ³ Kenney GM, Zuckerman S, Dubay L, et al. "Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?" Washington: The Urban Institute, 2012. <http://www.urban.org/publications/412630.html>; Holahan J, Buetgens M, Carroll C, et al. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." Washington: Kaiser Commission on Medicaid and the Uninsured, 2012. <http://www.urban.org/publications/412707.html>
- ⁴ Haley J and Kenney GM. "Uninsured Veterans and Family Members: Who Are They and Where Do They Live?" Washington: The Urban Institute, 2012. <http://www.urban.org/publications/412577.html>
- ⁵ *Federal Benefits for Veterans, Dependents and Survivors: Chapter 1 VA Health Care Benefits*. Washington: U.S. Department of Veterans Affairs, http://www.va.gov/vpa/publications/benefits_book/benefits_chap01.asp (accessed March 5, 2013).
- ⁶ Some dependents and survivors of veterans with service-connected disabilities are eligible for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), and certain veterans' children who have been diagnosed with spina bifida are entitled to VA health care benefits. (CHAMPVA. Washington: U.S. Department of Veterans Affairs, 2012. <http://www.va.gov/hac/forbeneficiaries/champva/champva.asp>; Spina Bifida. Washington: U.S. Department of Veterans Affairs, 2011. <http://www.va.gov/hac/forbeneficiaries/spina/spina.asp>; Panangala SV and Jansen DJ. TRICARE and VA Health Care: Impact of the Patient Protection and Affordable Care Act (P.L. 111-148). Washington: Congressional Research Service).
- ⁷ These thresholds reflect eligibility for comprehensive Medicaid or Medicaid-equivalent benefits. Some additional states offer more limited benefits to low-income adults. Heberlein M, Brooks T, Alker J, et al. *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP 2012-2013*. Washington: Kaiser Commission on Medicaid and the Uninsured, 2013. <http://www.kff.org/medicaid/upload/8401.pdf>
- ⁸ *Affordable Care Act and the Veterans Health Administration*. Washington: U.S. Department of Veterans Affairs, <http://www.va.gov/health/aca.asp> (accessed March 5, 2013); Panangala and Jansen 2010.
- ⁹ Heiss C and McMahon SM. "Veterans and the ACA: How Health Reform Boosts Eligibility for VA Health Care." Hamilton, NJ: Center for Health Care Strategies, 2012. http://www.chcs.org/nst_docs/Veterans_and_the_ACA2.pdf
- ¹⁰ Kenney et al.
- ¹¹ In contrast, just 1 in 10 veterans appears eligible for Medicaid under current law (Haley and Kenney 2012).
- ¹² 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 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 noninstitutionalized civilians.
- ¹³ *U.S. Census Bureau, American Community Survey: Response Rates—Data*. Washington: U.S. Census Bureau, 2012. http://www.census.gov/csr/www/methodology/response_rates_data/index.php. Additional details about the survey and our analysis are included in the appendix to Haley and Kenney 2012.
- ¹⁴ A small number of family members of veterans are identified by being the parent or sibling of a veteran between the ages of 19 and 22 who appears to be a full-time student and who lives in their household.
- ¹⁵ The Indian Health Service (IHS) is not typically counted as health insurance coverage because of limitations in the scope of available services and geographic reach of IHS facilities. Turner J and Boudreaux M. "Health Insurance Coverage in the American Community Survey: A Comparison to Two Other Federal Surveys." Databases for Estimating Health Insurance Coverage for Children: A Workshop Summary. Washington: National Academies Press, 2010.
- ¹⁶ State Health Access Data Assistance Center. "Comparing Health Insurance Estimates from the American Community Survey and the Current Population Survey." Princeton, NJ: Robert Wood Johnson Foundation, 2010. <http://www.shadac.org/files/shadac/publications/IssueBrief22.pdf>
- ¹⁷ Under the ACA, income eligibility will be based on the Internal Revenue Service tax definition of MAGI, and includes the following types of income for everyone who is not a tax-dependent child: wages, business income, retirement income, Social Security, investment income, alimony, unemployment compensation, and financial and educational assistance. The ACS asks only indirectly about unemployment compensation, alimony, Social Security, and financial and educational assistance when it asks about "other income," and because unemployment compensation appears to affect our results and "other income" includes any other sources of income, we compute the amount of unemployment compensation separately from other income amounts, based on imputations from a model developed for the Current Population Survey (CPS). MAGI also includes the income of any dependent children required to file taxes, which for 2009 is wage income greater than \$5,700 and investment income greater than \$950. To compute family income as a ratio of the poverty level, we sum the person-level MAGI across the tax unit. For ACA eligibility, the tax unit includes parents and their dependent children and married people regardless of whether they file separately. In situations where a dependent child is away at school, the ACS does not contain data on the family income and other family information on the child's record or the presence of the dependent child on the records of family members, so we assign some college students to families before computing family MAGI. While the ACA uses a threshold of 133 percent of FPL, a standard 5 percent disregard will be applied, bringing the threshold to 138 percent of FPL. Our income measure likely understates the number of people who will qualify for Medicaid under the ACA among those whose income fluctuates from month to month: eligibility will be determined using monthly income; however, the ACS collects income as an annual measure, and thus our monthly income variable represents an average for the calendar year. The definition of MAGI used here is an approximation of how income will be assessed for the purposes of determining eligibility for Medicaid under the ACA and is slightly different than the measure used in Haley and Kenney (2012), based on updated regulations that have been released. In particular, these estimates include Social Security income as part of MAGI, which is why the estimated number of uninsured veterans and family members with incomes below 138 percent of FPL is lower than in our earlier estimates.
- ¹⁸ Advisory Board Company.
- ¹⁹ Haley and Kenney.²⁰ Ibid.
- ²⁰ Kenney et al.
- ²¹ Haley and Kenney; Kenney et al.
- ²² Heberlein et al. Some of the family members of veterans below 138 percent of FPL, particularly children, would enroll in Medicaid/CHIP even if their state chooses not to expand Medicaid under the ACA, although the increased take-up of Medicaid and CHIP among current eligibles is expected to be higher in states that expand Medicaid under the ACA (Holahan et al. 2012). Children of veterans do not qualify for VA care.

²⁴ Compared to uninsured veterans, a lower share of uninsured family members are below 138 percent of FPL because uninsured veterans who do not live with nonelderly family members have lower income levels, on average, than those with family members in their households (Halley and Kenney 2012).

²⁵ Kenney et al.

²⁶ Enrollment in VA health care will fulfill the requirements for minimum essential coverage under the ACA (Panangala and Jansen 2010).

²⁷ Heiss and McMahon.

²⁸ *Potential Costs of Veterans' Health Care*. Washington: Congressional Budget Office, 2010. http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/118xx/doc11811/2010_10_7_vahcalthcare.pdf

²⁹ Ibid.

³⁰ Kizer KW. "Veterans and the Affordable Care Act." *Journal of the American Medical Association* 307, no. 8 (2012):789-790; Pizer SD and Gardner JA. 2011. "Is Fragmented Financing Bad for Your Health?" *Inquiry* 48:109-122.

³¹ *R--VA Implementation support for the Affordable Care Act (ACA)*, Washington: Federal Business Opportunities, 2013, <https://www.fbo.gov/ls=opportunity&mode=form&id=f6676dd7d6a2a513386467182e932085&tab=core&view=0>

³² Congressional Budget Office 2010; Kizer, Pizer and Gardner.

³³ Most uninsured veterans and spouses of veterans below 138 percent of FPL (about three-quarters) are ineligible for Medicaid under current law.

For the remainder, who appear eligible under current law, enrollment in Medicaid will likely grow due to the implementation of the ACA, although the increased take-up of Medicaid and CHIP among current eligibles is expected to be higher in states that expand Medicaid under the ACA (Holahan et al. 2012).

³⁴ Holahan et al.

³⁵ Institute of Medicine. *America's Uninsured Crisis: Consequences for Health and Health Care*. Washington: National Academies Press, 2009; Finkelstein A, Taubman S, Wright B, et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, Working Paper 17190. Cambridge, MA: National Bureau of Economic Research, 2011, <http://www.nber.org/papers/w17190>

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1 Before that though I wanted to touch on
2 one other group that was discussed and it's those
3 that Mr. Dominguez talked about and that is the
4 active duty, individuals on active duty. And that as
5 Jason was talking about, there are individuals
6 currently -- you know, this is -- this is an issue
7 about national readiness and making sure people are
8 prepared to go to combat. So we have General
9 Ashenhurst here to speak to that issue.

10 GENERAL ASHENHURST: President Cole,
11 Members of the Board, I am Debbie Ashenhurst, the
12 Adjutant General. I command over 16,000 of your
13 fellow Ohio citizens in the National Guard.

14 It's hard to categorize how many National
15 Guard members would be subject to or be eligible for
16 this because they have to self-report if they're
17 unemployed. And many of our guardsmen don't report
18 themselves as unemployed when they're students. And
19 the members of this legislature are very generous
20 with our guards members in that they pay 100 percent
21 tuition so many of our guardsmen don't have to work,
22 and they do just attend school.

23 Well, with the federal drawdown of funds
24 and as the war in Afghanistan and Iraq are coming to
25 a -- a reduction, I won't say a close, I have great

1 concerns about the medical readiness of our service
2 members because throughout this war we were always in
3 a state of preparing ourself to go to war, the
4 Federal Government provided great funds to keep our
5 service members at a pretty high state of medical
6 readiness.

7 I'm already seeing a degradation of those
8 services and those contracts that were available to
9 our service members to keep them medically ready,
10 dental and medical, that I have fears that -- that
11 now it's going to be back on me and the cost of the
12 individuals, whether they have insurance or don't
13 have insurance, to maintain that state of readiness.
14 And if post -- or pre911 is any indication of how
15 ready our service members are, it wasn't good. It
16 was not good.

17 So if a guardsman is solely reliant on
18 their guard pay, meaning if they are a 100 percent
19 paid tuition student, they go to school, and their
20 only income is their drill weekends and their annual
21 training, anybody under the grade of general officer
22 would qualify -- would benefit -- could benefit from
23 this expanded Medicaid. Now, I would say that's not
24 the majority of our guardsmen, you know, the majority
25 of our guardsmen where they are but particularly our

1 lower enlisted, our enlisted level 1s and 2s and 3s
2 and 4s are the most at risk of not being employed in
3 some manner in which they have access to other
4 insurance and are most likely to suffer and that is
5 the majority of our service members. I can't put a
6 number to that, but I can tell you I have fear as of
7 the impact of the reduction in medical services will
8 be.

9 Now, they have the ability to purchase
10 insurance through the military through Tricare. It's
11 \$52 a month. For some reason it's that same category
12 of young people that don't think they need to buy
13 insurance because they are, of course, invincible.
14 Just ask them.

15 So I have great concerns. You know, I
16 put a number out there of 400 known that would
17 certainly be impacted, but I will tell you the
18 potential is much greater for our guardsmen, your
19 fellow Ohioans, to be -- to benefit from this
20 Medicaid expansion.

21 PRESIDENT COLE: Thank you. Director
22 Plouck, follow-up on the local government impact?

23 DIRECTOR PLOUCK: President Cole and
24 Senator Sawyer, I did want to follow up on the local
25 government impact because, again, mental health and

Commentary: Sheriff, mental health board support Medicaid expansion

By TRAVIS HUTCHINSON and JUDY WORTHAM WOOD Published: January 20, 2013 4:00AM

As the Wayne County sheriff and executive director of the Mental Health and Recovery Board of Wayne and Holmes Counties, we strongly encourage Gov. John Kasich and local state legislators to support Medicaid expansion.

Medicaid expansion is critical for Wayne County families who need improved access to behavioral health services and will ultimately help us keep our communities safe. Expanding Medicaid will increase behavioral health service access to Wayne County uninsured adults up to 138 percent of the federal poverty level.

Starting in 2014, federal funding will be available and pay on average 95 percent for the following six years, therefore, providing critical funding during financially constrained times for state and county authorities. Law enforcement in Wayne and other Ohio counties every day see the sometimes tragic connection between crime and insufficient mental health services.

The Wayne County Sheriff's Office employs a mental health professional to evaluate incoming detained individuals, however, additional staff and resources are needed. We also recognize that while the Mental Health Court provides a critical role in assuring individuals needing mental health services are identified, the inability to assure essential mental health services follow-up and treatment contributes to repeat offenders.

This creates a "revolving door" scenario that drains local dollars and county resources. A better way is to have appropriate services provided at the first offense, which requires expanded resources, access and funding. Medicaid expansion is a pathway to this better way.

To put the need for expansion in further context, the Mental Health and Recovery Board provides funding for services for individuals who cannot afford services. However, 30 percent state funding cuts to community mental health in 2009-10 have not been fully restored, resulting in ongoing local service and program constraints. Expansion will increase funding for mental health and substance abuse treatment, as well as medical services for people at this income level. Increasing funding for these services is also cost-effective.

By treating mental illness in a consistent and timely manner, we will, in many instances, reduce costs associated with related physical problems, encourage treatment in community settings and provide quality alternatives to incarceration. We know from our mutual experience that Medicaid expansion makes good public policy and fiscal sense from our mental health and criminal justice perspectives, but also recognize that expansion is important for Ohio in other ways.

Last week a collaboration of nonpartisan experts unveiled a study, concluding that expansion actually will save the state dollars, increase jobs, particularly in the health care sector, and provide coverage to more than 400,000 Ohioans who are presently uninsured.

In conclusion, we again encourage Gov. Kasich and our state legislators to embrace the expansion opportunity. It is a once-in-a-lifetime opportunity to responsibly improve our behavioral health services, make our communities safer and do so in a way that it fiscally responsible.

Travis Hutchinson is Wayne County's sheriff and Judy Wortham Wood is the executive director of the Mental Health and Recovery Board of Wayne and Holmes Counties.



Could Medicaid expansion decrease drug court costs, save local taxpayer dollars? Cleveland judge says yes.

Sarah Jane Tribble, The Plain Dealer By Sarah Jane Tribble, The Plain Dealer

Email the author | Follow on Twitter

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"People who are drug dependent pay for their habits with petty crimes," Cuyahoga County Common Pleas Judge David Matia said.

CLEVELAND, Ohio -- Cuyahoga County Common Pleas Judge David Matia estimates that area residents could save millions in local taxes if the **offenders he sees in drug court** had health insurance.

About 1,000 people from Greater Cleveland Congregations listen to speakers arguing for Ohio Medicaid expansion during a **January gathering**. Greater Cleveland Congregations will canvas in Rocky River, Berea and Solon this week to urge people to contact their lawmakers in support of expansion. (Thomas Ondrey/The Plain Dealer)

And if Ohio were to expand Medicaid, as being debated by state legislators, many of the defendants in his court would qualify for the state and federal health insurance program for the poor.

Matia believes the cost-savings would be twofold: The court could redirect the money it currently spends on drug treatment to support services; and, he says, there would be fewer crimes, which cost individuals and the community, because many who need ongoing medication and therapy after being released from the justice system would have coverage.

"People who are drug dependent pay for their habits with petty crimes. The mentally ill, who are more likely to commit crimes of violence when they are un-medicated, are less likely to harm you, your neighbor, your child or your friend," he said.

Matia is not alone in his beliefs. In Cuyahoga County, local advocates who work in mental health and addiction services as well as hospitals and business owners support his contention.

William Denihan, chief executive officer of the The Alcohol, Drug Addiction & Mental Health Services, or ADAMHS, board of Cuyahoga County said he would welcome redirecting the county tax dollars now used to pay for drug treatment. Other areas he said could use additional funding include housing, prevention services, employment training, some detoxification services, and peer support programs,

Last year, Cuyahoga County taxpayers spent an estimated \$5.8 million on 2,100 people who, under expansion, could qualify for Medicaid and needed services because of drug addiction or mental illness, Denihan said.

Nationally, **experts have studied** how health coverage for those struggling with addiction and mental illness could impact the crime rate and, cost taxpayers who foot the bill for courts and jails less.

Researchers at the George Washington University reported in a **November 2012 paper** that those people released from jail with Medicaid coverage had reduced recidivism rates and the time between offenses was longer than those without health care.

The researchers note that a study of jail inmates with serious mental illness in King County, Washington, and Pinellas County, Florida, with Medicaid coverage had, on average, 16 percent fewer subsequent detentions. In Washington, those released with Medicaid were 60 percent more likely to get mental health services than those who no longer had Medicaid. In Florida, inmates released with Medicaid were 30 percent more likely to access services.

"Although not without its challenges, extending coverage to this highly vulnerable population would result in significant cost savings for states and counties," the researchers wrote.

The federal Affordable Care Act allows states to chose if they want to extend Medicaid to adults under the age of 65, who are without any children, and earn up to 138 percent of the federal poverty level. That's \$15,856 for a single adult, \$21,404 for a couple and \$32,499 for a family of four.

The federal government would pay 100 percent of the health care costs of newly qualified individuals for three years. After that, the federal government would cover 95 percent and phase down to 90 percent. For states that choose to expand, the program will take effect January 1.

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Ohio is one of **more than two-dozen states** that are opposed to or undecided about whether to expand Medicaid. Both Ohio's House and Senate have failed to fully support Gov. John Kasich's budget, which includes Medicaid expansion. And, in recent weeks, the two have created separate working committees to explore the pros and cons of expansion. Ohio's lawmakers must vote before July 1, the beginning of the next fiscal year, on a state budget.

Some lobbyist and political watchers predict that rather than putting Medicaid expansion in the budget, a separate bill could be introduced later this year. Others have begun exploring a ballot option to let the state's residents vote on expansion next year.

Greg Lawson, statehouse liaison and policy analyst for the conservative policy group Buckeye Institute, said stories of human suffering like those found in the criminal justice system are compelling but he doesn't believe offering more health insurance is the solution.

Instead, he said, there needs to be "overarching systematic reform that will offer assistance to these people. . . there are more ways to deal with this issue than to simply say we have to expand this one program."

As the clock ticks on a decision, local lobbying for expansion has stepped up: On Monday, community activists held a rally at the Neighborhood Family Practice Center, a federally qualified community health center on Cleveland's West Side. In addition, Greater Cleveland Congregations announced that dozens of volunteers from area religious organizations and neighborhood groups will go door to door in the legislative swing districts of Rocky River, Berea and Solon this week to urge people to contact their legislators.

Last week, Cleveland City Councilman Joe Cimperman, who said the city has passed several resolutions in support of expansion, held a special committee meeting. The small City Hall committee room was standing room only with about 40 advocates and others who might benefit from the expansion there to speak and show support.

Donna Strugar-Fritsch, a principal with the national health policy consulting firm Health Management Associates, said it's difficult to predict exactly how much money would be saved if criminals had the type of regular health care coverage provided by Medicaid.

Strugar-Fritsch said prison and jail populations nationwide are a "**sick crowd**" with higher rates of hypertension, asthma and arthritis than the general population. And after being released, offenders don't have access to ongoing care for mental and physical health problems.

"Anything that we can do that can keep people from re-entering the criminal justice system -- which Medicaid could do if it's done right -- then it can only help everybody," she said.

One day recently in drug court, a man in his late 20s stood in front of Matia and explained that he had been too sick to meet with sponsors and follow the court's detoxification program: "I've been having a lot of pain and just haven't been doing that well."

Matia looked at him and asked "Do you have insurance?"

The man looked straight at the judge and said, "No."

After the court session ended, veteran case manager Donna Woods said that if he'd had insurance, he would have had a relationship with caregivers and could have turned to professionals for help.

"It's a huge point that people seem to overlook," Woods said.

The suffering caused by being sick, she said, isn't "Republican or Democratic, it's human."

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