The Affordable Care Act (ACA) provided for the states to expand Medicaid to everyone with income less than 138% of the Federal Poverty Level (FPL). The Supreme Court ruling in June 2012 made the Medicaid expansion optional for the states. Under the ACA, the federal government pays 100% of the cost of Medicaid for newly eligible people from January 2014 to December 2016. Starting in 2017, the federal share of Medicaid funding will decline each year, reaching 90% in 2020 and continuing at 90% in 2021 and beyond. This contrasts with the 63% share of Medicaid costs that the federal government paid in 2012 for currently eligible people. That share will continue with minor year-to-year adjustments. Ohio has not yet decided whether to expand Medicaid coverage under the ACA.

To fully understand the effect of Medicaid expansion on the state and residents of Ohio, The Health Foundation of Greater Cincinnati supported two analyses of the expansion.

- **Expanding Medicaid In Ohio: Preliminary Analysis of Likely Effects**: Urban Institute, Ohio State University, REMI, Inc. and the Health Policy Institute of Ohio (Jan. 15, 2013)
- **Policy Considerations for Medicaid Expansion in Ohio**: Health Policy Institute of Ohio (January 2013)

The findings from these two analyses informed the Health Foundation’s opinion that expanding Medicaid would benefit Ohio. The following highlights from the reports influenced the Foundation to support Medicaid expansion.

*All numbers are for years 2014-2022.*
IMPACT ON OHIO’S BUDGET AND ECONOMY

State of Ohio Expenses

- The increased cost of the Medicaid expansion to the state of Ohio will be $2.497 billion.
- The state will save $1.030 billion on what it already pays for healthcare for several groups that become eligible for Medicaid under the expansion.

State of Ohio Revenues

- State revenues (taxes, managed care plans, general revenue and drug rebates) will increase by $2.898 billion.
- Ohio’s net income from Medicaid expansion will be $1.432 billion. That is, Ohio will take in $1.432 billion more than it will spend.

Other financial benefits from the expansion:

- Increased healthcare activity will raise $387 million in county sales taxes.
- Employers will save $1.659 billion that they would spend on insurance for their low-income employees if there is no Medicaid expansion.
- Low-income uninsured Ohioans will save $7.415 billion out of pocket (or receive that amount of charity care) for healthcare costs if Medicaid is expanded.
- Medicaid expansion will add 31,800 new jobs, generating $17.520 billion in increased earnings.

Covering other ACA expenses

If Ohio does not implement Medicaid expansion, there will still be a large increase in enrollment of people who are already eligible for Medicaid,
but not enrolled. Without the expansion, Ohio’s Medicaid net state costs will increase because of other changes under the ACA.

- Ohio will spend $2.302 billion more for the increased enrollment of people who are currently eligible, but not enrolled.
- Revenue increases, drug rebates and managed care taxes will offset $2.264 billion.
- The net fiscal impact of the ACA being implemented without Medicaid expansion will be $0.038 billion (i.e., $38 million) higher net state cost.

**Economic Impact Summary**

- An expansion would generate new state Medicaid costs.
- It would allow state budget savings and increase state revenue.
- State savings because of the Medicaid expansion would exceed the relatively modest net state costs resulting from the ACA’s other provisions.
- Medicaid expansion would reduce the number of uninsured, increase Ohio employment and earnings, improve county finances, and lower healthcare costs for Ohio’s employer and residents.

**IMPACT ON OHIOANS’ COVERAGE AND ACCESS TO HEALTHCARE**

The Ohio Medicaid program currently covers people with disabilities and seniors living with income up to 64% FPL, parents with dependent children living up to 90% FPL, children and pregnant women living up to 200% FPL, and workers with disabilities living up to 250% FPL. The expansion will primarily affect uninsured single adults with incomes up to 138% FPL. If
Ohio expands Medicaid, the expansion will cover about 456,000 Ohioans by 2022. Even with the expansion, 635,000 Ohioans may remain uninsured.

If Ohio does not expand Medicaid, Ohioans who earn between 100% and 138% FPL will be eligible for a premium subsidy of insurance bought through the health insurance exchange. Some of these, however, may not be able to afford the subsidized insurance. Ohioans with incomes below 100% FPL currently ineligible for Medicaid will remain uninsured and will not be eligible for subsidies for insurance purchased on the health insurance exchange (Tax subsidies are for those living between 100% and 400% FPL).

A 2009 Institute of Medicine report found that health insurance coverage is critical for gaining access to appropriate healthcare services. People with insurance are more likely to access preventive care, have fewer avoidable hospitalizations and have better health outcomes.

**IMPACT ON PROVIDERS**

Separate from the ACA, current federal law requires states to operate a Disproportionate Share Hospital (DSH) program that partially pays hospitals for uncompensated or free care provided to low-income and uninsured patients. Ohio’s DSH program, funded by a tax on hospitals, is the Hospital Care Assurance Program (HCAP). HCAP requires Ohio hospitals to give free necessary medical care to people who are uninsured with incomes up to 100% FPL. Many hospitals also provide charity care to people with incomes above 100% FPL.

Because there will be fewer uninsured people under the ACA, DSH payments to hospitals will be reduced by $18.1 billion over six years. From 2014 through 2020, payments are reduced to about 75% of their current level. Now that Medicaid expansion is optional, the number of uninsured will not drop as much as planned in states that do not expand Medicaid. As a result, hospitals may be paid less for providing similar amounts of uncompensated care.

In reaching our conclusion about Medicaid expansion, we also considered that:

- Uninsured people and their families who obtain Medicaid will be more secure and less disrupted by financial instability.
- Medicaid expansion will remove most of the incentive for people with health problems to avoid employment. They will not lose Medicaid coverage until their income exceeds 137% FPL. At that point, under the ACA, they will be able to buy subsidized insurance through the exchange.

**CONCLUSION**

This summary covers many of the points that influenced the Health Foundation opinion about Medicaid expansion in Ohio. The full reports that follow are publicly available for readers to form their own opinion about Medicaid expansion. The Health Foundation of Greater Cincinnati believes that it is in the best interests of Ohioans in general, as well as in our own area, to take advantage of this unprecedented opportunity.
EXPANDING MEDICAID IN OHIO
preliminary analysis of likely effects

Revised: January 18, 2013

Funded by
The Health Foundation of Greater Cincinnati, The Mt. Sinai Health Care Foundation and The George Gund Foundation

About the study

• Partnership of Regional Economic Models, Inc., the Urban Institute, Ohio State University and Health Policy Institute of Ohio

• Funded by the Health Foundation of Greater Cincinnati, the Mt. Sinai Health Care Foundation and the George Gund Foundation

• Designed to analyze 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 Urban Institute’s Health Insurance Policy Simulation Model (HIPSM)

- HIPSM is a “microsimulation model,” like the model used by the Congressional Budget Office and the U.S. Treasury Department.
- 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, 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.

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, GRP, 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 also 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.
Key questions

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**?

---

Current Medicaid eligibility

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>400% FPL</td>
<td></td>
</tr>
<tr>
<td>250% FPL</td>
<td></td>
</tr>
<tr>
<td>200% FPL</td>
<td></td>
</tr>
<tr>
<td>138% FPL</td>
<td></td>
</tr>
<tr>
<td>100% FPL</td>
<td></td>
</tr>
</tbody>
</table>

- **children**
- **pregnant women**
- **parents**
- **childless adults**
- **disabled workers**
- **disabled**

01.18.2013
Subsidized health coverage eligibility for Ohioans in 2014
with ACA Medicaid expansion

Subsidized health coverage eligibility for Ohioans in 2014
without ACA Medicaid expansion
Initial caveats

- Projections inherently involve uncertainty.
- These estimates are preliminary and subject to change.
- Future analyses will include additional estimates that are developed using other methods.
- While the specific numbers may change from the findings presented here, the basic results are likely to stay the same.
Federal government share
Percentage of health care costs paid by the federal government, newly eligible adults vs. other adults: 2014-2020 and beyond

![Graph showing the percentage of health care costs paid by the federal government.]

01.18.2013

State cost of expansion
Impact of Medicaid expansion on state Medicaid spending: FY 2014-2022 (millions)

![Graph showing the state cost of expansion.]

Source: Urban Institute HIPS M 2013. Note: Figure does not include savings resulting from higher federal matching rates for certain current beneficiaries.

01.18.2013
Does a Medicaid expansion allow state budget savings?

Spend-down adults would become newly eligible adults, receiving higher federal match

- Today, they qualify after incurring medical bills
- With expansion, they would qualify immediately as newly eligible adults, without incurring medical bills
- Medicaid would cover more of their health costs, but the federal government would pay a much higher share of their Medicaid costs, resulting in net state savings

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Net savings on spend-down adults (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$36</td>
</tr>
<tr>
<td>2015</td>
<td>$74</td>
</tr>
<tr>
<td>2016</td>
<td>$78</td>
</tr>
<tr>
<td>2017</td>
<td>$80</td>
</tr>
<tr>
<td>2018</td>
<td>$82</td>
</tr>
<tr>
<td>2019</td>
<td>$86</td>
</tr>
<tr>
<td>2020</td>
<td>$87</td>
</tr>
<tr>
<td>2021</td>
<td>$91</td>
</tr>
<tr>
<td>2022</td>
<td>$96</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>$709</strong></td>
</tr>
</tbody>
</table>

*Source: OSU 2013.*
Women with breast and cervical cancer would become newly eligible adults, receiving higher federal match

- Today, they qualify for the Breast and Cervical Cancer Program (BCCP) after receiving a diagnosis from a CDC-affiliated clinic.
- With an expansion, they would qualify immediately as newly eligible adults, with the federal government paying a higher share of costs, resulting in state savings.

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>BCCP savings (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$2</td>
</tr>
<tr>
<td>2015</td>
<td>$5</td>
</tr>
<tr>
<td>2016</td>
<td>$5</td>
</tr>
<tr>
<td>2017</td>
<td>$5</td>
</tr>
<tr>
<td>2018</td>
<td>$6</td>
</tr>
<tr>
<td>2019</td>
<td>$6</td>
</tr>
<tr>
<td>2020</td>
<td>$6</td>
</tr>
<tr>
<td>2021</td>
<td>$6</td>
</tr>
<tr>
<td>2022</td>
<td>$7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$48</strong></td>
</tr>
</tbody>
</table>

*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.*

Inpatient prison health care would be covered by Medicaid

- Medicaid does not cover most prison health care, but it can cover inpatient and institutional care that inmates receive off the prison grounds.
- Almost all prisoners would qualify as newly eligible adults under an expansion.

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Savings on inpatient care to prisoners (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$15</td>
</tr>
<tr>
<td>2015</td>
<td>$31</td>
</tr>
<tr>
<td>2016</td>
<td>$32</td>
</tr>
<tr>
<td>2017</td>
<td>$32</td>
</tr>
<tr>
<td>2018</td>
<td>$32</td>
</tr>
<tr>
<td>2019</td>
<td>$32</td>
</tr>
<tr>
<td>2020</td>
<td>$33</td>
</tr>
<tr>
<td>2021</td>
<td>$33</td>
</tr>
<tr>
<td>2022</td>
<td>$34</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$273</strong></td>
</tr>
</tbody>
</table>

*Source: OSU 2013.*
Other possible savings

- Enhanced federal match for **family planning waiver program** participants, who become newly eligible adults
- Pending federal policy decisions, the following groups could receive greatly increased federal matching payments as newly eligible adults up to 138 percent of FPL:
  - Pregnant women
  - Transitional Medical Assistance (TMA) families
- Saving on non-Medicaid **mental health substance abuse treatment services** currently funded by the state
- Savings on other **state non-Medicaid programs** that provide health care to the poor uninsured
- Potentially reduced **criminal justice costs** if the poor and near-poor uninsured receive improved access to mental health and substance abuse treatment

Does a Medicaid expansion **increase state revenue?**
More Medicaid managed care enrollment would increase state sales tax and insurance tax revenue

- Managed care premium payments include:
  - 5.5 percent state sales tax
  - 1.0 percent state health insurance tax
- With expansion, most new Medicaid spending will pay managed care premiums

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Revenue (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$38</td>
</tr>
<tr>
<td>2015</td>
<td>$118</td>
</tr>
<tr>
<td>2016</td>
<td>$166</td>
</tr>
<tr>
<td>2017</td>
<td>$202</td>
</tr>
<tr>
<td>2018</td>
<td>$226</td>
</tr>
<tr>
<td>2019</td>
<td>$242</td>
</tr>
<tr>
<td>2020</td>
<td>$259</td>
</tr>
<tr>
<td>2021</td>
<td>$277</td>
</tr>
<tr>
<td>2022</td>
<td>$295</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,823</strong></td>
</tr>
</tbody>
</table>

Source: Urban Institute HIPSM 2013. Note: This table includes both state and federal payments for tax surcharges, since our cost estimates include state payment of these taxes. Because state payment of managed care taxes is treated in the same way for both cost estimates and revenue estimates, the two estimates can be combined to show net state budget effects. The table also takes into account revenue lags.

Federal Medicaid dollars in Ohio
Impact of expansion on federal Medicaid dollars in Ohio: FY 2014-2022 (millions)

Source: Urban Institute HIPSM 2013. Note: Figure does not include effects of higher federal matching rates for certain current beneficiaries.
Impact on general state revenue

Medicaid expansion increases economic activity, which raises general state revenue

- Medicaid expansion increases the amount of federal money buying health care from Ohio providers
- Ohio providers use that money to buy other goods and services, much of which is within the state
- The resulting economic activity increases general state revenue

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>General revenue (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$25</td>
</tr>
<tr>
<td>2015</td>
<td>$61</td>
</tr>
<tr>
<td>2016</td>
<td>$82</td>
</tr>
<tr>
<td>2017</td>
<td>$97</td>
</tr>
<tr>
<td>2018</td>
<td>$106</td>
</tr>
<tr>
<td>2019</td>
<td>$113</td>
</tr>
<tr>
<td>2020</td>
<td>$118</td>
</tr>
<tr>
<td>2021</td>
<td>$124</td>
</tr>
<tr>
<td>2022</td>
<td>$132</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>$857</strong></td>
</tr>
</tbody>
</table>

Source: REMI 2013. Note: Results include effects of increased economic activity on state sales tax and individual and corporate income tax revenues. Results take into account the loss of federal exchange subsidy dollars under a Medicaid expansion.

01.18.2013

Prescription drug rebates

Drug manufacturers rebate to the state a portion of Medicaid drug costs

- Prescription drug manufacturers rebate to the state and federal governments a portion of Medicaid's prescription drug costs.
- Because the state pays little or nothing for newly eligible adults, the state receives only a small amount of rebate revenue.

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>State rebates (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$1</td>
</tr>
<tr>
<td>2015</td>
<td>$3</td>
</tr>
<tr>
<td>2016</td>
<td>$3</td>
</tr>
<tr>
<td>2017</td>
<td>$20</td>
</tr>
<tr>
<td>2018</td>
<td>$25</td>
</tr>
<tr>
<td>2019</td>
<td>$31</td>
</tr>
<tr>
<td>2020</td>
<td>$43</td>
</tr>
<tr>
<td>2021</td>
<td>$45</td>
</tr>
<tr>
<td>2022</td>
<td>$47</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>$218</strong></td>
</tr>
</tbody>
</table>

Source: OSU 2013.
What is the net effect on the state budget?

Overall impact of expansion on state budget (millions)

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Increased state costs from more Medicaid enrollment</th>
<th>Savings (spend-down adults, BCCP, inpatient prison costs)</th>
<th>Revenue (taxes on managed care plans, general revenue, drug rebates)</th>
<th>Net state fiscal gains</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$13</td>
<td>$53</td>
<td>$63</td>
<td>$104</td>
</tr>
<tr>
<td>2015</td>
<td>$30</td>
<td>$109</td>
<td>$183</td>
<td>$262</td>
</tr>
<tr>
<td>2016</td>
<td>$38</td>
<td>$115</td>
<td>$251</td>
<td>$328</td>
</tr>
<tr>
<td>2017</td>
<td>$145</td>
<td>$117</td>
<td>$318</td>
<td>$290</td>
</tr>
<tr>
<td>2018</td>
<td>$280</td>
<td>$119</td>
<td>$357</td>
<td>$197</td>
</tr>
<tr>
<td>2019</td>
<td>$343</td>
<td>$124</td>
<td>$386</td>
<td>$167</td>
</tr>
<tr>
<td>2020</td>
<td>$466</td>
<td>$126</td>
<td>$420</td>
<td>$80</td>
</tr>
<tr>
<td>2021</td>
<td>$572</td>
<td>$130</td>
<td>$445</td>
<td>$3</td>
</tr>
<tr>
<td>2022</td>
<td>$609</td>
<td>$137</td>
<td>$473</td>
<td>$1</td>
</tr>
<tr>
<td>Total:</td>
<td>$2,497</td>
<td>$1,030</td>
<td>$2,898</td>
<td>$1,431</td>
</tr>
</tbody>
</table>

Note: Table does not include potential savings from TMA coverage, Medicaid coverage of pregnant women or family planning waivers, savings on non-Medicaid spending for substance abuse treatment and other care to the poor uninsured, other criminal justice savings, or administrative cost effects.
Medicaid expansion, state budget effects: FY 2014-2022 (millions)

How does a Medicaid expansion affect Ohioans?
Fewer uninsured

The number of Ohio uninsured who would gain coverage from a Medicaid expansion: FY 2014-2022 (thousands)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>252</td>
<td>302</td>
<td>381</td>
<td>430</td>
<td>449</td>
<td>451</td>
<td>453</td>
<td>454</td>
<td>456</td>
</tr>
</tbody>
</table>

Source: Urban Institute HIPSM 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.

The number of Ohio uninsured, with and without the ACA, with and without a Medicaid expansion (thousands)

Source: Urban Institute HIPSM 2013. FY 2014 results are for January through June 2014.
Impact on Ohio economy
The effects of additional federal Medicaid dollars on the Ohio economy

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Increased employment</th>
<th>Increased earnings (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>9,459</td>
<td>$487</td>
</tr>
<tr>
<td>2015</td>
<td>22,657</td>
<td>$1,227</td>
</tr>
<tr>
<td>2016</td>
<td>28,384</td>
<td>$1,660</td>
</tr>
<tr>
<td>2017</td>
<td>31,210</td>
<td>$1,963</td>
</tr>
<tr>
<td>2018</td>
<td>32,033</td>
<td>$2,168</td>
</tr>
<tr>
<td>2019</td>
<td>31,989</td>
<td>$2,317</td>
</tr>
<tr>
<td>2020</td>
<td>31,599</td>
<td>$2,429</td>
</tr>
<tr>
<td>2021</td>
<td>31,401</td>
<td>$2,551</td>
</tr>
<tr>
<td>2022</td>
<td>31,872</td>
<td>$2,718</td>
</tr>
</tbody>
</table>

Total: $17,520

Source: 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.

Impact on Ohio health care costs
The effect of Medicaid expansion on health care costs for Ohio employers and consumers (millions)

Without a Medicaid expansion:
• Employers will provide health coverage to some poor or near-poor consumers who, under the ACA’s original design, were slated to be enrolled in Medicaid
• Poor and near-poor consumers who could have enrolled in Medicaid instead will be uninsured or obtain insurance with cost-sharing well above Medicaid levels

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Increased employer costs, without an expansion</th>
<th>Increased consumer costs, without an expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$9</td>
<td>$308</td>
</tr>
<tr>
<td>2015</td>
<td>$61</td>
<td>$657</td>
</tr>
<tr>
<td>2016</td>
<td>$135</td>
<td>$733</td>
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<tr>
<td>2017</td>
<td>$191</td>
<td>$803</td>
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<td>2018</td>
<td>$222</td>
<td>$865</td>
</tr>
<tr>
<td>2019</td>
<td>$236</td>
<td>$920</td>
</tr>
<tr>
<td>2020</td>
<td>$252</td>
<td>$979</td>
</tr>
<tr>
<td>2021</td>
<td>$268</td>
<td>$1,042</td>
</tr>
<tr>
<td>2022</td>
<td>$285</td>
<td>$1,109</td>
</tr>
</tbody>
</table>

Total: $1,659 | $7,415

Impact on county sales tax revenue

A Medicaid expansion would increase county sales tax revenue

- In the aggregate, counties receive sales tax revenue equal to 1.35 percent of Medicaid managed care premiums
- With an expansion, most new Medicaid spending will pay managed care premiums

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Estimated revenue (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$9</td>
</tr>
<tr>
<td>2015</td>
<td>$27</td>
</tr>
<tr>
<td>2016</td>
<td>$36</td>
</tr>
<tr>
<td>2017</td>
<td>$43</td>
</tr>
<tr>
<td>2018</td>
<td>$48</td>
</tr>
<tr>
<td>2019</td>
<td>$51</td>
</tr>
<tr>
<td>2020</td>
<td>$54</td>
</tr>
<tr>
<td>2021</td>
<td>$58</td>
</tr>
<tr>
<td>2022</td>
<td>$62</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>$387</strong></td>
</tr>
</tbody>
</table>

Source: Urban Institute HIPSM 2013. Estimates assume the same revenue lags that apply to state sales taxes.

Impact on local mental health costs

Medicaid would cover mental health treatment for the previously uninsured poor, which now is primarily locally funded

- State and local funds paid $98 million in FY 2011 for services to the uninsured and underinsured that could have been covered by Medicaid. Since then, all or most of these costs have shifted entirely to local level.
- Even with a Medicaid expansion, some current clients would remain uninsured.
- The table suggests the general magnitude of potential savings. It shows what would happen if, starting on January 1, 2014, if local spending was reduced by 50 percent on current costs for potentially Medicaid-covered services now provided to the uninsured and underinsured.

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Rough estimate of potential local savings (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$27</td>
</tr>
<tr>
<td>2015</td>
<td>$58</td>
</tr>
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<td>2016</td>
<td>$61</td>
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<td>2017</td>
<td>$64</td>
</tr>
<tr>
<td>2018</td>
<td>$67</td>
</tr>
<tr>
<td>2019</td>
<td>$71</td>
</tr>
<tr>
<td>2020</td>
<td>$75</td>
</tr>
<tr>
<td>2021</td>
<td>$79</td>
</tr>
<tr>
<td>2022</td>
<td>$83</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>$583</strong></td>
</tr>
</tbody>
</table>

Source: MHAC and CCS 2012. Note: This table trends forward FY 98 costs assuming national per capita cost growth for all health care services, as projected by the Center for Medicare and Medicaid Services Office of the Actuary.
Other economic considerations for counties

• With an expansion, Medicaid will pay for many people who otherwise would have received health care funded entirely at county expense. Accordingly, some counties can reduce or reinvest the prior health care spending for people who are poor and uninsured.

• Increased economic activity due to more federal Medicaid dollars buying Ohio health care will increase general county revenues.
Impact of the ACA’s non-expansion provisions on state Medicaid costs: FY 2014-2022 (millions)


State budget impact of ACA without expansion: cost of increased enrollment among current eligibles (millions)

Source: Urban Institute HIPSM 2013. Note: Figure does not include effects of higher federal matching rates for certain current beneficiaries.
### Savings and revenue from ACA provisions other than expansion, FY 2014-2022 (millions)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>CHIP match increase*</th>
<th>Prescription drug rebates</th>
<th>State managed care tax</th>
<th>General state revenue from increased growth</th>
<th>Net offsets to increased costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$0</td>
<td>$6</td>
<td>$8</td>
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<td>$86</td>
<td>$19</td>
<td>$23</td>
<td>$58</td>
<td>$186</td>
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<tr>
<td>2016</td>
<td>$90</td>
<td>$24</td>
<td>$30</td>
<td>$85</td>
<td>$229</td>
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<tr>
<td>2017</td>
<td>$94</td>
<td>$27</td>
<td>$34</td>
<td>$103</td>
<td>$258</td>
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<tr>
<td>2018</td>
<td>$98</td>
<td>$29</td>
<td>$38</td>
<td>$110</td>
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<tr>
<td>2019</td>
<td>$102</td>
<td>$32</td>
<td>$41</td>
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<td>2020</td>
<td>$107</td>
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<td>2021</td>
<td>$112</td>
<td>$38</td>
<td>$48</td>
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<tr>
<td>2022</td>
<td>$117</td>
<td>$41</td>
<td>$52</td>
<td>$138</td>
<td>$348</td>
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<tr>
<td>Total</td>
<td>$806</td>
<td>$251</td>
<td>$318</td>
<td>$889</td>
<td>$2,264</td>
</tr>
</tbody>
</table>

* The 2020 CHIP savings estimate assumes that federal CHIP allotments continue beyond 2015 and that the ACA’s 23 FPL percentage point match increase is implemented and continues through 2021.

**Source:** Urban Institute HiPSM 2013; OSU 2013; REMI 2013.

### Overall impact of the ACA’s non-expansion provisions on the state budget (millions)

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Increased state costs from more enrollment</th>
<th>Net offsets to increased costs</th>
<th>Net fiscal impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$76</td>
<td>$36</td>
<td>($40)</td>
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<tr>
<td>2015</td>
<td>$177</td>
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<td>2017</td>
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<td>2018</td>
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<tr>
<td>2020</td>
<td>$315</td>
<td>$310</td>
<td>($5)</td>
</tr>
<tr>
<td>2021</td>
<td>$343</td>
<td>$329</td>
<td>($14)</td>
</tr>
<tr>
<td>2022</td>
<td>$370</td>
<td>$348</td>
<td>($22)</td>
</tr>
<tr>
<td>Total</td>
<td>$2,302</td>
<td>$2,264</td>
<td>($38)</td>
</tr>
</tbody>
</table>

*Note: Table does not include potential savings from higher federal match rates for eligibility systems or savings from shifting into the exchange current Medicaid adults over 100 or 138 percent of FPL.*
Other potential offsets from the ACA’s non-expansion provisions

- **Higher federal matching rates** for eligibility systems
- **Shifting into the exchange** Medicaid adults who have incomes above 100 or 138 percent FPL
- Increased revenue from **insurance taxes** on health coverage sold in the health insurance exchange

The ACA’s impact on the state budget, with and without a Medicaid expansion: FY 2014-2022 (millions)

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Impact of the Medicaid expansion (slide 24)</th>
<th>Impact of ACA, without expansion (slide 38)</th>
<th>Net impact of the ACA, with Medicaid expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$104</td>
<td>($40)</td>
<td>$64</td>
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<tr>
<td>2015</td>
<td>$262</td>
<td>$9</td>
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<td>2016</td>
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<td>2017</td>
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<td>2018</td>
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<tr>
<td>2020</td>
<td>$80</td>
<td>($5)</td>
<td>$75</td>
</tr>
<tr>
<td>2021</td>
<td>$3</td>
<td>($14)</td>
<td>($11)</td>
</tr>
<tr>
<td>2022</td>
<td>$1</td>
<td>($22)</td>
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<tr>
<td><strong>Total:</strong></td>
<td><strong>$1,431</strong></td>
<td><strong>($38)</strong></td>
<td><strong>$1,393</strong></td>
</tr>
</tbody>
</table>
Conclusions

• **A Medicaid expansion** would *generate new state Medicaid costs*.

• Because it would also allow state budget savings and increase state revenue, **a Medicaid expansion would improve the Ohio state budget picture** in the 2014-2022 period—particularly during the next several biennia.

• State **savings due to the Medicaid expansion** would *exceed* the relatively modest net **state costs** resulting from **the ACA’s other provisions** for the next four biennia, after which the savings would nearly equal the costs.

• A Medicaid expansion would **reduce the number of uninsured, increase Ohio employment and earnings, improve county finances**, and **lower health care costs** for Ohio’s employers and residents.

Further work

• Data in this presentation will be refined and released, along with related additional material, as a brief in mid-February

• In the coming months, the study partners will:
  • Refine this set of projections
  • Release another set of projections, based on OSU’s actuarial model
  • Identify more specific local impacts, including regional and, in some cases, county-level revenue, jobs, economic activity and health coverage
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43 01.18.2013

Supplemental material

44 01.18.2013
Previously unenrolled people who join Medicaid under the ACA, with and without a Medicaid expansion: FY 2014-22 (thousands)

What about Medicaid administrative costs?

- The ACA’s non-expansion provisions will affect state administrative costs
  - Changes to Medicaid and CHIP eligibility, including major investments in information technology (IT), will raise administrative costs
  - Provider payment increases and other requirements will increase administrative costs
  - Medicaid must process applications that arrive from the health insurance exchange
  - Federal funding will cover a much higher percentage of IT eligibility costs
- It is unclear whether the expansion itself would raise or lower overall state administrative costs
  - Factors that increase costs
    - Some additional increase in initial applications
    - More eligibility redeterminations
    - More fee-for-service claims
  - Factors that reduce costs
    - Fewer spend-down determinations
    - Fewer disability determinations
    - Fewer fair hearings for eligibility denials

Federal subsidies in the exchange, with and without Medicaid expansion: FY 2014-22 (millions)

Uninsured Ohioans under the ACA, with and without a Medicaid expansion: Calendar Year 2022 (thousands)

Will the ACA cause a major increase in enrollment by eligible seniors?

What happened when states expanded coverage over the past decade?
Maine’s 2002 reforms

Average annual increase in Medicaid enrollment, U.S. vs. Maine: June 2002 to June 2004

Note: Enrollment totals for adults and children, broken out separately, are not available for this time period.

Massachusetts’s 2006 reforms

Average annual increase in Medicaid enrollment, U.S. vs. Massachusetts: June 2006 to June 2008

Source: Health Management Associates/Kaiser Commission on Medicaid and the Uninsured 2009. Note: Totals for adults include seniors. Increases in non-elderly adults were higher than the adult amounts shown here.
Wisconsin’s 2008-2009 reforms

Average annual increase in Medicaid enrollment, U.S. vs. Wisconsin: June 2008 to June 2010

- Children: 7.9% (U.S. average), 12.0% (Wisconsin)
- All adults: 7.1% (U.S. average), 15.8% (Wisconsin)
- Seniors and people with disabilities: 3.2% (U.S. average), 4.6% (Wisconsin)

Source: Health Management Associates/Kaiser Commission on Medicaid and the Uninsured 2012. Note: Totals for adults include seniors. Increases in non-elderly adults were higher than the adult amounts shown here.
Introduction
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), which for a family of three is $26,344 annually (see chart below).

The option that states have to expand Medicaid is unprecedented. Since the Medicaid program is a state-federal partnership, the federal government has restricted whether and how states could expand Medicaid coverage.

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. In June 2012, the U.S. Supreme Court made expansion of Medicaid optional, rather than required.

There are significant policy considerations regarding a Medicaid expansion, including:
• Impact on Ohio’s budget and economy
• Impact on coverage, access and quality of care
• Impact on the private insurance market and providers

This brief is one of a series of publications HPIO plans to release in 2013 related to Medicaid expansion. The purpose of this brief is to provide background on the issue of Medicaid expansion, outline policy considerations, and provide a summary analysis of the costs and benefits of a Medicaid expansion. HPIO also is partnering with several organizations on more detailed, Ohio-specific research related to Medicaid expansion that will be released later in January 2013. The Health Policy Institute of Ohio (HPIO) will release its updated, biennial publication, “Ohio Medicaid Basics,” in early 2013.

Background
The primary goal of the ACA is to expand access to health insurance coverage, thereby reducing the uninsured population. The main mechanisms for expanding coverage under the ACA are:
• Changes to health insurance regulation
• Subsidies for insurance purchased through a health insurance exchange (“exchange”) available for people with incomes between 100% and 400% of FPL
• Medicaid expansion for people with incomes up to 138% of FPL (see chart above)

Together, these policies were designed to provide coverage for most Americans. At least for the short term, the majority of Americans will continue to have employer-sponsored insurance coverage.
A note about 133% FPL and 138% FPL
The Affordable Care Act provides for an expansion of Medicaid to 133% of the federal poverty level (FPL). The law also standardizes how income is counted and establishes a 5% income disregard. For this reason, the effective eligibility level is up to 138% FPL.

Medicaid coverage now and under the ACA
Currently, the federal government requires state Medicaid programs to cover certain categories of individuals, including some children and pregnant women with incomes at or near FPL, some parents with incomes well below FPL and people who are aged, blind and disabled and meet other specific requirements. The federal government does not require coverage of adults without dependent children. In most states, coverage of parents is limited to very low income individuals. In Ohio, only parents with income below 90% FPL are eligible for Medicaid.

Beginning in 2014, the ACA required states to expand Medicaid coverage to all individuals under the age of 65 with incomes up to 138% FPL who legally reside in the U.S. and do not qualify for Medicare. Under the ACA, the federal government could withhold all existing Medicaid funding from states that did not agree to implement the expansion. On June 28, 2012, the United States Supreme Court upheld the constitutionality of the ACA but found unconstitutional the provision to eliminate existing program funding for states choosing not to expand Medicaid. As a result, Medicaid expansion became optional for states.

Key factors underlying a Medicaid expansion are:
- The federal government pays 100% of the cost of covering people who are newly eligible for Medicaid from 2014 through 2016. After 2016, enhanced federal funding gradually decreases to a minimum of a 90% match.
- States have the flexibility of whether and when to implement the expansion, although the years for 100% federal funding are fixed.
- States that implement the expansion can later decide to roll it back.
- Enhanced federal funding is not available for a partial Medicaid expansion, although the federal government will consider proposals for partial expansion at the regular federal matching rate.
- With minor exceptions, the decision facing states is whether to expand Medicaid to 138% FPL with enhanced federal match, or to not expand at all.

How will Medicaid expansion impact Ohio’s budget and economy?
Expanding Medicaid will require additional state investment, but not immediately. According to Ohio Medicaid’s initial estimates, Medicaid expansion would cost the state an additional $203 million in CY2017 and $256 million in CY2018. Because the federal government pays the full cost for people who are newly eligible from 2014 through 2016, the state share of the Medicaid expansion is zero for these years. Medicaid administrative costs will continue to be reimbursed at a federal/state match rate of 50/50, whether or not Ohio expands Medicaid.
The Urban Institute estimates that Ohio's spending from 2014-2019 could increase anywhere from $172 million to $1.3 billion if the ACA is fully implemented. This analysis considered all effects of the ACA, not just the Medicaid expansion.

A later Urban Institute analysis, focused specifically on the Medicaid expansion, found that when a reduction in spending on uncompensated care is included, adding the Medicaid expansion to the rest of the ACA would increase Ohio's share of the ten-year cost by approximately $3.1 billion – a 3.2% increase in state Medicaid costs.

In addition to the state and Urban Institute, a number of credible organizations have estimated the cost of implementing the ACA, including the Heritage Foundation, the Kaiser Family Foundation and the Robert Wood Johnson Foundation. Variability and assumptions in these estimates results from differences in accounting for several factors, including:

- How the source and year of baseline data on which estimates are based (i.e. Census data, Ohio Family Health Survey/Ohio Medicaid Assessment Survey data) is selected

People who are currently Medicaid eligible but not enrolled

Because of several factors, some people who are currently eligible but not yet enrolled in Medicaid will enroll in or after 2014, regardless of whether eligibility expands. Some refer to this phenomenon as the “woodwork” or “welcome mat” effect.

These factors include:

- The requirement to have health insurance
- Interfaces between the exchange and Medicaid
- Increased awareness regarding the availability of health coverage

The state will receive the regular federal match rate for this population, resulting in higher state Medicaid costs. Ohio initially estimated that the five year state share cost for these individuals will be $2.87 billion whether or not Ohio expands Medicaid.

- Whether the cost of enrolling currently eligible, but not enrolled, people is included in the cost of Medicaid expansion
• How the number of people currently privately insured but who may enroll in Medicaid if offered the opportunity is calculated
• How simplified application processes may impact Medicaid enrollment
• How outreach efforts, or the lack thereof, impact Medicaid enrollment
• How the individual mandate affects Medicaid enrollment
• Whether or how potential savings are calculated to estimate a net cost
• The time period over which the costs/savings are calculated

While there are costs associated with expanding Medicaid when the 100% federal funding is reduced in 2017, Medicaid expansion is likely to generate additional revenue in terms of sales, income and other taxes. For example, the existing state managed care organization sales tax could

Ohio Medicaid Expansion Study
Three foundations — the Health Foundation of Greater Cincinnati, the Mt. Sinai Health Care Foundation and the George Gund Foundation — are funding the Ohio Medicaid Expansion Study to provide state policymakers with additional analysis on the costs and benefits of Medicaid expansion.

The study, which is a partnership between the Health Policy Institute of Ohio (HPIO), The Ohio State University (OSU), Regional Economic Models, Inc. (REMI), and the Urban Institute, will examine key questions including:
• How many people who are currently eligible but not enrolled will enroll in Medicaid even without an expansion? How much will that cost the state?
• How many additional people will receive coverage if Ohio also expands Medicaid? How much more will that cost the state?
• If Ohio expands Medicaid, how much could it save in General Revenue Fund dollars by moving current beneficiaries into coverage for which the federal government pays 90% to 100% of all health care costs?
• How much could Ohio save by reducing state and local spending on residents without insurance who would enroll in Medicaid under an expansion?
• How does bringing more federal dollars into Ohio affect jobs, economic activity, and state and local revenue?
• How would the effects of expansion change over time as the federal government reduces its share of newly eligible adults’ costs from 100% to 90%?
• Do the state revenues earned under Medicaid expansion cover the state costs associated with Medicaid expansion even when the state share increases to 10% in 2020?
• To what extent do the state revenues earned under Medicaid expansion and other program savings help offset the Medicaid costs that Ohio will experience without Medicaid expansion per year?
• How would Medicaid expansion affect revenues, jobs, and coverage at the county level?

The study will address these questions by analyzing the impact of a Medicaid expansion and no Medicaid expansion on:
• The state budget
• Ohio economic growth
• Ohio jobs
• The number of people with Medicaid coverage
• The number of people with and without health coverage
• Health coverage, jobs, economic growth, and revenue in each Ohio county

Statewide findings will be released in January 2013, with local findings released in February 2013.
generate additional revenues under an expansion.

To date, no research has estimated these new revenues. In addition, no research has examined in detail Ohio’s specific circumstances and calculated the number of Ohioans expected to gain coverage, or the costs, revenues, and the overall economic impact of a Medicaid expansion on Ohio. Savings from an expansion, such as the coverage with higher federal match of people currently covered by other Ohio programs, has also not been assessed. The “Ohio Medicaid Expansion Study,” to be released early in 2013, will analyze these issues more closely (see box on page 4).

How will Medicaid expansion impact Ohioans without insurance coverage?

The Ohio Medicaid program currently covers people with disabilities and seniors up to 64% FPL, parents with dependent children up to 90% FPL, children and pregnant women up to 200% FPL, and workers with disabilities up to 250% FPL. Like most states, Ohio does not cover adults without dependent children.

Ohio’s decision on the Medicaid expansion will primarily affect people who are uninsured or underinsured and have incomes up to 138% FPL. If Ohio does not expand Medicaid coverage up to 138% FPL:

- Some Ohioans with incomes below 100% FPL will remain without access to Medicaid and will not be eligible for subsidies in an exchange.
- Ohioans with incomes between 100-138% FPL will be eligible for premium subsidies to purchase coverage in the exchange. However, even with subsidies, this coverage may remain unaffordable for some.

Nationally, among those who would be newly Medicaid eligible under an expansion, about one-third will have income between 100-138% FPL and about two-thirds will have income below 100% FPL. This means that in states that do not expand Medicaid, the majority of uninsured adults with incomes up to 138% FPL will remain without access to subsidized health coverage.

For uninsured Ohioans, the cost of insurance coverage is a primary barrier. Uninsured
rates vary across income, with higher uninsured rates at lower incomes. Thirty-eight percent of Ohio adults ages 19-64 with incomes up to 138% FPL are uninsured, compared to the overall adult uninsured rate of 19% in Ohio. Expanding Medicaid may narrow this coverage gap.

The graphs on page 5 illustrate who would be eligible for Medicaid under a Medicaid expansion and who would remain ineligible for Medicaid and be without subsidized coverage if there is no expansion.

Estimates indicate that if all provisions of the ACA are implemented, including the Medicaid expansion, nearly 800,000 currently uninsured Ohioans may gain health coverage by 2017, although the number could range from a low of 500,000 to a high of one million. About 62% of those uninsured would gain coverage through Medicaid. Another study found that by 2022 there will be 684,000 new Medicaid enrollees in Ohio– 457,000 of whom will have moved from the ranks of uninsured to insured.

Even if Ohio expands Medicaid coverage, there will still be a substantial number of uninsured. One study estimates that there will be 700,000 uninsured Ohioans in 2017. Another study estimates 600,000 uninsured Ohioans in 2022. These will primarily be people who voluntarily go without coverage, some of which may be subject to a tax penalty – which is lower in 2014 and 2015 than in subsequent years.

How will Medicaid expansion impact providers?

Reduction in Disproportionate Share Hospital payments

Separate from Medicaid, 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. Ohio’s DSH program is the Hospital Care Assurance Program (HCAP), funded by a tax on hospitals. HCAP requires Ohio hospitals to give free necessary medical care to people who are uninsured with incomes up to 100% FPL. Many hospitals also provide charity care to low income individuals above 100% FPL.

Impact of Medicaid expansion on private insurance market

Ohio’s decision regarding the Medicaid expansion will affect the private insurance market. The American Academy of Actuaries identified several issues for policymakers to examine as they consider Medicaid expansion:

• Not expanding Medicaid may increase insurance rates in the individual market. People with incomes between 100-138% FPL who enroll in coverage through exchanges are expected to have higher health care needs than people with higher-incomes. As a result, the Congressional Budget Office (CBO) estimates that average individual market premiums will be two percent higher than original estimates if states choose not to expand Medicaid up to 138% FPL.

• From 2014 to 2016, a federal program provides payments to individual market insurance plans for their high-cost enrollees in the exchanges to help stabilize the market. Funding for this program is fixed, meaning this could result in a lower per-enrollee payment due to higher exchange enrollment. This also could contribute to higher premiums in the exchange.

• The ACA provides that employers with 50 or more employees are subject to penalties if any full-time employee receives a premium subsidy for coverage in the exchange. In states that do not expand Medicaid, workers who would have been eligible for Medicaid may decide to enroll in coverage through the exchange and access subsidies, raising employer penalties.

Those who support private, market-based strategies to health coverage express concern that expanding a public program such as Medicaid may potentially weaken the private insurance market by encouraging people to enroll in public programs over private insurance.
Due to the expected decrease in uninsured as a result of health reform, the 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. However, now that Medicaid expansion is optional, states choosing not to expand Medicaid will not experience as large of a drop in uninsured as previously expected. As a result, hospitals may be paid less for providing similar amounts of uncompensated care.

Regardless of whether Medicaid is expanded, hospitals may seek to recover losses resulting from a decrease in DSH payments bypressuring the state to supplement DSH reductions, providing less uncompensated or charity care, passing on the costs of uncompensated care to the privately insured through price increases, or eliminating services.

Shift from private to public coverage
A study of Medicaid expansions implemented in four states (Massachusetts, New Jersey, California and Wisconsin) found that some people will drop private coverage when offered Medicaid. Some of those moving from private coverage to Medicaid were underinsured, with inadequate coverage and high premiums, deductibles or copayments. Underinsured individuals are more likely to apply for hospital charity care programs or have unpaid medical bills. As a result, Medicaid coverage for these individuals may reduce medical bankruptcies or other financial challenges caused by high medical costs while also decreasing hospital bad debt and uncompensated care.

However, Medicaid has a physician reimbursement rate that is lower than both private insurance and Medicare. Consequently, a significant shift of Ohioans from private coverage to Medicaid may decrease how much hospitals and physicians are paid.

How will Medicaid expansion impact access?
A 2009 Institute of Medicine report found that health insurance coverage is a critical tool for gaining access to appropriate health care services. Specifically, compared to uninsured individuals, insured adults and children were more likely to:

- Have access to preventative care
- Experience fewer avoidable hospitalizations
- Have better health outcomes for a number of acute and chronic conditions

While Medicaid expansion, coupled with other ACA reforms, is expected to increase the number of insured Ohioans, there is concern that expansion of coverage will result in inadequate access to health care providers and greater unmet need. Parts of Ohio already face primary care shortages.

How will Medicaid expansion impact quality of care?
Studies have shown varying results as to the impact of Medicaid coverage on health outcomes. Some studies link Medicaid coverage to greater adverse outcomes in adults, while other studies suggest that Medicaid coverage has little to no impact on infant and child mortality. However, other studies have demonstrated positive outcomes. In Oregon, researchers found that relative to uninsured low-income adults, new Medicaid recipients had less medical debt, used more health care, and reported better physical and mental health.
In 2012, there were 1,217,355 Ohioans living in a primary care Health Professional Shortage Area (HPSA). 43 671,531 of whom were estimated to be underserved. 44 Expansions of coverage under the ACA could contribute to this trend, at least in the short term. 45

Creating sustainable workforce capacity
The ACA provides a number of additional funding opportunities aimed at helping states build their workforce to bridge service gaps and meet the anticipated increase in demand for services. ACA initiatives include:

- Grants to support primary care training programs, traineeships and fellowships, including physician assistant training programs in primary care
- Grants to medical schools for the training and recruitment of rural physicians
- Funding to support increasing the supply of pediatric subspecialists, dental providers and geriatricians
- Support for nursing student loans, educational programs, and development of nursing faculty

A number of trends within health care could also help address provider capacity issues, including:

- The use of telehealth to bridge gaps in specialty and rural care (i.e. technology based practices such as e-consultations and digital photography)
- The growth of care coordination and team-based approaches to care delivery, such as accountable care organizations (ACOs) and patient-centered medical homes (PCMHs)

The impact of efforts to increase and redistribute the supply of the workforce to meet anticipated service demand will likely not be seen for some time. 55

Ohio’s safety net system
Safety net providers are health care providers who currently provide a substantial share of health care to the uninsured, Medicaid, and other vulnerable populations. Safety net providers include hospitals, physician practices, rural health clinics, community health centers, community

Medicaid physician payment rates
Low Medicaid payment rates for physicians could make access challenging for people with Medicaid coverage. A number of studies have demonstrated that an increase in access to services is related to how much physicians are paid. 46 Currently, Medicaid pays physicians at a rate lower than both private insurance and Medicare. As of 2012, Medicaid’s payment rate in Ohio was at 61% of Medicare’s for all services – the number dropping to 59% for primary care services. 47 Consequently, it is primarily Medicaid’s low payment rates that have deterred physician participation in Medicaid. 48 Notably, in 2011, only 72% of office-based physicians in Ohio accepted new Medicaid patients. 49

Separate from but related to the Medicaid expansion, the ACA provides a fully federally funded Medicaid payment rate increase for primary care services to 100% of Medicare payment levels. 50 This increases payments for primary care services in Ohio by more than 70% in 2013. 51 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. 52

However, the payment increase applies only to certain providers who deliver primary care services 53 in 2013 and 2014 – although states have the option to continue the payment increase with state funding. 54 The overall and long-term impact on physician participation in Medicaid, specifically for specialists, is unclear.
mental health centers, and free clinics. Safety net providers do not serve all areas in Ohio and, in some cases, are not able to provide all medically necessary services.61

Many safety net providers are struggling to maintain their operations and meet the increased demand for services caused by the economic downturn.62 A Medicaid expansion will create another source of payment for these providers, but will also likely increase the demand for services. To help support the safety net system and enable safety net providers to expand their capacity, the ACA provides $11 billion in dedicated federal funding for community health centers, awarded on a competitive basis nationwide. The funding, which started in 2011 and continues for five years, will expand capacity at existing health centers as well as add new health centers for communities in need.63

Even if Ohio expands Medicaid coverage, 700,000 Ohioans may still be uninsured.64 Consequently, it is important that funding for safety net providers to provide care for the uninsured not be eliminated.

Conclusion
With the exception of when the program was created in the 1960s, the option that states have to expand Medicaid is unprecedented. The decision carries fiscal, budgetary and public policy implications. Research suggests that there is variability in what the impacts of a Medicaid expansion on Ohio may be. Furthermore, there are valid points made by both those in favor and those concerned about an expansion. As a result, it is necessary that the full spectrum of costs, revenues and the impact of the ACA both with and without implementation of a Medicaid expansion are thoroughly examined prior to making the decision on whether Ohio should or should not expand Medicaid.
1. Federal Poverty Level (FPL) are annually updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for various federal and state programs.


5. Ohio’s current FMAP is approximately 64% federal and 36% state.

6. Ohio Medicaid is updating these figures based on more current data and information in preparation for the release of the state biennial budget in February 2013.

7. Ohio Medicaid included in its cost projections an extension of the primary care physician rate increase beyond CY 2013-14, the years for which the federal government is funding the entire cost of the increase.

8. Ohio is currently required by law to cover these eligible people if they enroll.


21. Employees are eligible for premium subsidies if they are not eligible for Medicaid, and if their employer does not offer insurance that meets coverage and eligibility requirements. See Patient Protection and Affordable Care Act, §1401. Uninsured tax credit providing premium assistance for coverage under a qualified health plan. http://docs.house.gov/energycommerce/ppacaon.pdf


41. Ibid.


43. HPSA is a geographic area, population group, or health care facility that has been designated by the federal government as having a shortage of health professionals. Because communities apply for and must meet defined criteria for this designation, there are likely additional communities in Ohio that meet the criteria but have not applied. As a result, the number of Ohioans living in shortage areas is likely higher.


45. The Affordable Care Act requires most U.S. citizens to have health insurance and will provide access to coverage through premium subsidies for some populations and the option for states to expand Medicaid. As a result, up to 32 million people may be newly insured, many of whom will seek a source for primary care.


49. Decker, Sandra L. “In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help.” Health Affairs 31, no. 8 (2012): 1673-1679.


52. Ibid.

Glossary

Affordable Care Act (ACA) — The federal health care reform law enacted in March 2010. 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 designation that assists with medical expenses for poor individuals who are aged 65 years or older, blind or disabled (disability as classified by the Social Security Administration for an adult or child).

Categorically needy — refers to people who are both categorically-eligible for Medicaid and who need Medicaid services due to low incomes and/or few assets. State plans must cover people who are categorically needy in order to receive money from the federal government.

Centers for Medicare and Medicaid Services (CMS) — The federal agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs (Titles XVII and XIX of the Social Security Act). Formerly the Health Care Financing Administration (HCFA). www.cms.gov

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. 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.

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 public programs.

Health disparities — Differences in health outcomes that are closely linked with social, economic and/or environmental disadvantage.

Health insurance exchange — A way to pool risk, a competitive insurance marketplace where individuals and small businesses can shop for, compare and purchase affordable qualified health benefit plans. Exchanges offer a choice of health plans that meet certain benefits and cost standards. The ACA requires affordable health insurance exchanges to be established in every state. States have the option to establish a state-run exchange, participate in a federal exchange, or develop a hybrid exchange with state and federal roles starting in 2014. Ohio has elected to establish a hybrid, or partnership exchange, whereby the federal government will run the exchange with the state retaining responsibility for determining who qualifies for Medicaid and enforcing rules on plan benefits.

Individual mandate — Enacted under the ACA, a requirement that all individuals obtain minimum coverage health care insurance or pay a monetary penalty beginning in 2014. Some exceptions do apply (financial hardship, religious reasons). The penalty, in the form of a tax, will be $95 per individual or up to 1% taxable income in 2014, whichever is lower. It increases to $325 or up to 2% taxable income in 2015 and $695 or up to 3% taxable income in 2016.

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 federally–aided, state administered and jointly funded health insurance program that provides health and long-term care services to certain populations of low-income individuals and to aged, blind and disabled individuals meeting certain requirements. The program is subject to broad federal guidelines, and states determine the benefits covered and methods of administration. The federal government supports state administration by providing matching funds and establishing general programmatic guidelines. Medicaid is the largest provider of coverage for children, with 38 percent of Ohio children covered in 2010.

Uncompensated care — Service provided by physicians and hospitals for which no payment is received from the patient or from third–party payers.