healthpolicybrief

hpio health policy institute of ohio

Policy considerations for Medicaid expansion in Ohio

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)[1], 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.

2012 Federal Poverty Level (FPL) Guidelines
(by household size)

	90%	100%	138%	200%	250%	400%
1	$10,053	$11,170	$ 15,415	$22,340	$ 27,925	$44,680
2	$13,617	$15,130	$ 20,879	$ 30,260	$ 37,825	$ 60,520
3	$17,181	$19,090	$ 26,344	$ 38,180	$ 47,725	$ 76,360
4	$20,745	$23,050	$ 31,809	$46,100	$ 57,625	$92,200

Note: Annual guidelines for all states except Alaska, Hawaii and DC

Source: *Federal Register*, Vol. 77, No. 17, January 26, 2012, pp. 4034-4035

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.[2] 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.[3]

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.

Medicaid expansion Federal Medical Assistance Percentages (FMAP)
for new eligibles*

2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020+	90%

* The FMAP schedule is fixed.
Source: ACA §2001(3)(B).

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.

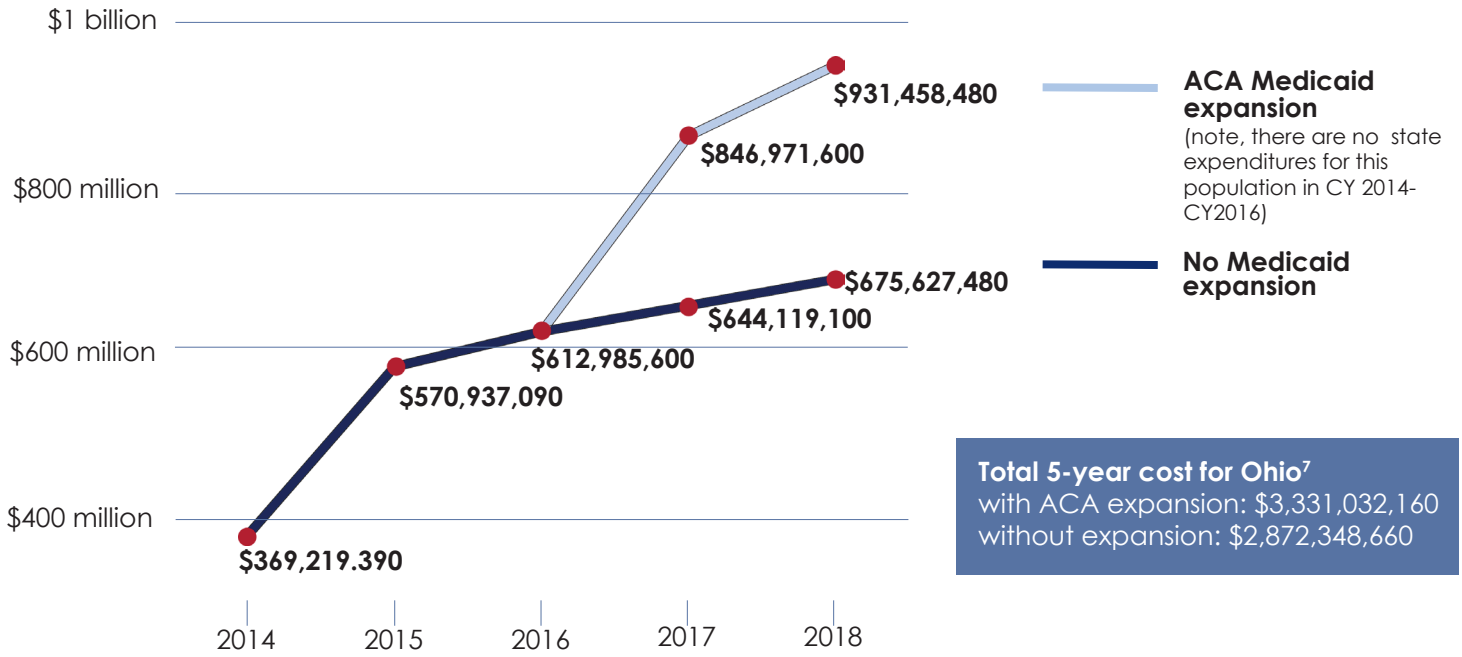
Key factors underlying a Medicaid expansion are:

- 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.[4,5]
- 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.[6] 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.

State share of Medicaid cost associated with the ACA



Source: Ohio Medicaid
Note: Ohio Medicaid's cost projections include an extension of the primary care physician rate increase for CY2015-CY2018. The ACA only requires and pays for that increase through CY2014.

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.[9] 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.[10]

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
- Whether the cost of enrolling currently eligible, but not enrolled, people is included in the cost of Medicaid expansion

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.[8] 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.

- 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.

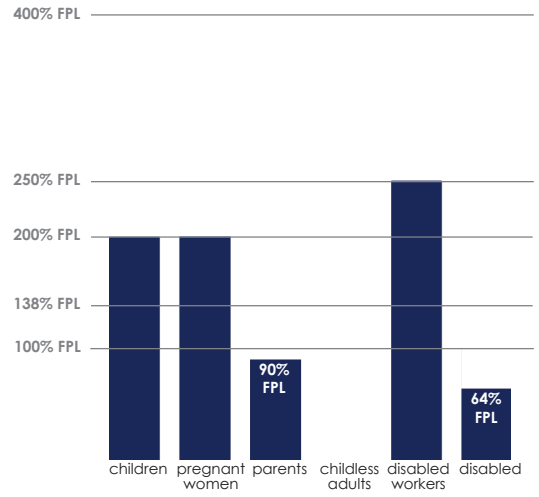
Ohio's decision on the Medicaid expansion will primarily affect people who are uninsured or underinsured and have incomes up to 138% FPL. If Ohio does not expand Medicaid coverage up to 138% FPL:

- 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.

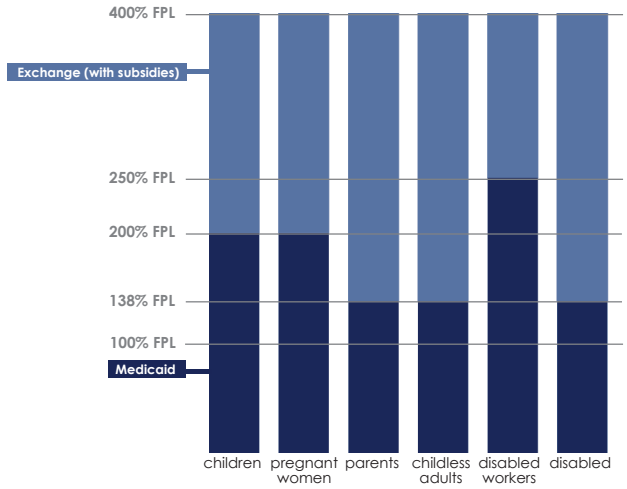
Nationally, among those who would be newly Medicaid eligible under an expansion, about one-third will have income between 100-138% FPL and about two-thirds will have income below 100% FPL.[11] This means that in states that do not expand Medicaid, the majority of uninsured adults with incomes up to 138% FPL will remain without access to subsidized health coverage.

For uninsured Ohioans, the cost of insurance coverage is a primary barrier. Uninsured

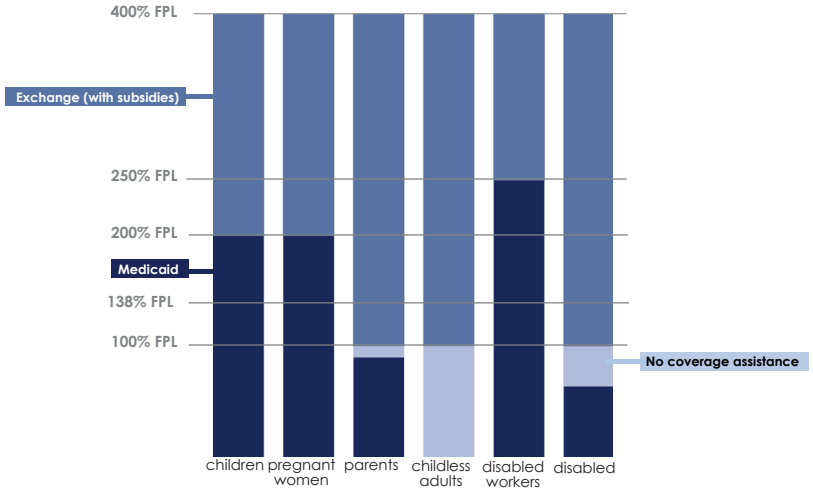
Current Medicaid eligibility



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



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



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.[12] 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.[13] About 62% of those uninsured would gain coverage through Medicaid.[14] 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.[15]

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.[16] Another study estimates 600,000 uninsured Ohioans in 2022.[17] 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.[18]

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.[24] 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.[25] Many hospitals also provide charity care to low income individuals above 100% FPL.[26]

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:[19]

- Not expanding Medicaid may increase insurance rates in the individual market.[20] 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.[21]
- 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.[22] 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.[23]

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.[27] 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.[28] 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.[29]

Regardless of whether Medicaid is expanded, hospitals may seek to recover losses resulting from a decrease in DSH payments by pressuring 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.[30]

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.[31] Some of those moving from private coverage to Medicaid were underinsured, with inadequate coverage and high premiums, deductibles or copayments.[32] Underinsured individuals are more likely to apply for hospital charity care programs or have unpaid medical bills.[33] 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.[34]

However, Medicaid has a physician reimbursement rate that is lower than both private insurance and Medicare.[35] 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 [42]

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.[36] 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.[37] However, other studies have demonstrated positive outcomes.[38] 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.[39]

A more recent study, released in November of 2012, suggests that previous studies did not account for Medicaid patients being in typically poorer health than non-Medicaid patients.[40] This same study compared health outcomes for states that expanded Medicaid to those of neighboring states that did not. Researchers found that compared to neighboring states, states that expanded Medicaid experienced reductions in mortality and delayed care, and improved self-reported health status.[41]

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.

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

A closer look at Massachusetts

In 2006, Massachusetts put into place a number of health care reforms that led to near universal health care coverage of its population – with more than 98% of the state insured by 2010.[56] The reforms, affecting both the public and private health insurance markets, resulted in 439,000 more Massachusetts residents gaining health coverage.

In the two years following Massachusetts' reform, a study by the Urban Institute suggested that while there had been significant improvements in access to care and health care use, there were also reported barriers to accessing care. Adults in Massachusetts reported not being able to get an appointment in the early period of reform and experiencing delayed care.[57] The study also found that emergency room visits increased – potentially reflecting issues of provider capacity and an increase in barriers to care during that initial period.[58]

However, according to the Massachusetts Health Reform Survey, by 2010 a greater percentage of adults were receiving preventative care services and reporting a usual source of care.[59] Furthermore, over the six year period since reform, the state saw a decline in inpatient days and emergency department use. While one in five nonelderly adults reported that they had difficulty finding a physician to see them, this number was lower in 2010 than 2006.[60]

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.

Notes

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.
2. "How is the Affordable Care Act Leading to Changes in Medicaid Today?" Kaiser Commission on Medicaid and the Uninsured. May 2012 http://www.kff.org/medicaid/upload/8312.pdf
3. Government Accounting Office, "Estimates of the Effect on the Prevalence of Employer-Sponsored Health Coverage." July 2012 http://www.gao.gov/assets/600/592411.pdf
4. December 10, 2012, "Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid ", Centers for Medicaid and Medicare Services. Downloaded 12/10/2012 at http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf.
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- 2014, 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.
9. Dorn, Stan, Caitlin Carroll, and Matthew Buettgens. "Consider Savings as Well as Costs." The Urban Institute (2011). http://www.urban.org/uploadedpdf/412361-consider-savings.pdf
10. Holahan, John, Matthew Buettgens, Caitlin Carroll, and Stan Dorn. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." (2012). http://www.kff.org/medicaid/upload/8384.pdf.
11. Congressional Budget Office. "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision." July 2012. http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf
12. The Kaiser Family Foundation, State Health Facts. http://www.statehealthfacts.org/
13. Palmer, Jeremy D., Jill S. Herbold, Paul R. Houchens, and Andrew L. Naugle. Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange. Milliman, 2011. http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf.
14. Palmer, Jeremy D., Jill S. Herbold, Paul R. Houchens, and Andrew L. Naugle. Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange. Milliman, 2011. http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf. Additional calculations by Health Policy Institute of Ohio.
15. Holahan, John, Matthew Buettgens, Caitlin Carroll, and Stan Dorn. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." (2012). http://www.kff.org/medicaid/upload/8384.pdf.
16. Palmer, Jeremy D., Jill S. Herbold, Paul R. Houchens, and Andrew L. Naugle. Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange. Milliman, 2011. http:// www.ohioexchange.ohio.gov/Documents/MillimanReport. pdf.
17. Holahan, John, Matthew Buettgens, Caitlin Carroll, and Stan Dorn. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." (2012). http://www.kff.org/medicaid/upload/8384.pdf.
18. Palmer, Jeremy D., Jill S. Herbold, Paul R. Houchens, and Andrew L. Naugle. Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange. Milliman, 2011. http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf. Additional calculations by Health Policy Institute of Ohio. See also Buettgens, Matthew, and Mark A. Hall. "Who will be uninsured after health insurance reform?" Robert Wood Johnson Foundation. March 2011.
19. American Academy of Actuaries, "Decision Brief: Implications of Medicaid Expansion Decisions on Private Coverage." September 2012.
20. Ibid.
21. Congressional Budget Office. "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision." July 2012. http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf
22. 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, Refundable tax credit providing premium assistance for coverage under a qualified health plan. http://docs.house.gov/energycommerce/ppacacon.pdf
23. Blase, Brian. "Obamacare and Medicaid: Expanding a Broken Entitlement and Busting\ State Budgets." WebMemo #3107. Heritage Foundation. Last modified January 19, 2011. http://www.heritage. org/research/reports/2011/01/obamacare-and-medicaidexpanding- a-broken-entitlement-and-busting-state-budgets.
24. Graves, John A. "Medicaid Expansion Opt-Outs and Uncompensated Care." New England Journal of Medicine 367, no. 25 (2012): 2365-2367.
25. Ohio Hospital Association (OHA) Factsheet
26. Ibid.
27. Patient Protection and Affordable Care Act, Title III, Subtitle B, Part III, Section 3133. The "American Taxpayer Relief Act of 2012" (otherwise known as the 'fiscal cliff deal'), which passed on January 1, 2013, includes additional cuts to the Medicaid DSH program.
28. Patient Protection and Affordable Care Act, Title III, Subtitle B, Part III, Section 3133.
29. Graves, John A. "Medicaid Expansion Opt-Outs and Uncompensated Care." New England Journal of Medicine 367, no. 25 (2012): 2365-2367.
30. Ibid.
31. Long, Sharon K., Stephen Zuckerman, and John A. Graves. "Are adults benefiting from state coverage expansions?." Health Affairs 25, no. 2 (2006): w1-w14.
32. Long, Sharon K., Stephen Zuckerman, and John A. Graves. "Are adults benefiting from state coverage expansions?." Health Affairs 25, no. 2 (2006): w1-w14.
33. Lavarreda, Shana Alex, E. Richard Brown, and Claudie Dandurand Bolduc. "Underinsurance in the United States: An interaction of costs to consumers, benefit design, and access to care." Annual Review of Public Health 32 (2011).
34. Holahan, John, Matthew Buettgens, Caitlin Carroll, and Stan Dorn. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." (2012). http://www.kff.org/medicaid/upload/8384.pdf.
35. Zuckerman, Stephen, and Dana Goin. "How much will Mediaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees." (2012). http://www.kff.org/medicaid/upload/8398.pdf. As of 2012, Medicaid's payment rate in Ohio was at 61% of the level of Medicare for all services and at 59% for primary care services.
36. Allen H, Baicker K, Finkelstein A, Taubman S, Wright BJ. What the Oregon Health Study can tell us about expanding Medicaid. Health Aff (Millwood) 2010; 29:1498-506. See also Currie J, Gruber J. Saving babies: the efficacy and cost of recent expansions of Medicaid eligibility for pregnant women. J Polit Econ 1996;104:1263-96.

37. Levy, Helen, and David Meltzer. "What do we really know about whether health insurance affects health." Health Policy and the Uninsured (2004): 179-204. See also Howell, Embry M. "The impact of the Medicaid expansions for pregnant women: a synthesis of the evidence." Medical Care Research and Review 58, no. 1 (2001): 3-30.
38. Kwok, Joseph, Scott M. Langevin, Athanassios Argiris, Jennifer R. Grandis, William E. Gooding, and Emanuela Taioli. "The impact of health insurance status on the survival of patients with head and neck cancer." Cancer 116, no. 2 (2010): 476-485. See also Gaglia, Michael A., Rebecca Torguson, Zhenyi Xue, Manuel A. Gonzalez, Itsik Ben-Dor, Gabriel Maluenda, Michael Mahmoudi et al. "Effect of insurance type on adverse cardiac events after percutaneous coronary intervention." The American journal of cardiology 107, no. 5 (2011): 675-680.
39. Finkelstein, Amy, Sarah Taubman, Bill Wright, Mira Bernstein, Jonathan Gruber, Joseph P. Newhouse, Heidi Allen, and Katherine Baicker. The Oregon health insurance experiment: evidence from the first year. No. w17190. National Bureau of Economic Research, 2011.
40. Sommers, Benjamin D., Katherine Baicker, and Arnold Epstein. "Mortality and access to care among adults after state Medicaid expansions." The New England Journal of Medicine. 2012.
41. Ibid.
42. Institute of Medicine (US). Committee on the Consequences of Uninsurance. (2009). America's Uninsured Crisis: Consequences for Health and Health Care. National Academy Press.
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.
44. The Kaiser Family Foundation, State Health Facts. http://www.statehealthfacts.org/
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.
46. White, Chapin. "A Comparison of Two Approaches to Increasing Access to Care: Expanding Coverage versus Increasing Physician Fees." Health Services Research (2012).
47. Zuckerman, Stephen, and Dana Goin. "How much will Mediaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees." (2012). http://www.kff.org/medicaid/upload/8398.pdf.
48. Cunningham, Peter J., and Len M. Nichols. "The effects of Medicaid reimbursement on the access to care of Medicaid enrollees: a community perspective." Medical Care Research and Review 62, no. 6 (2005): 676-696.
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.
50. "Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program." U.S. Department of Health and Human Services. Federal Register. Vol. 77, No. 215 (November 6, 2012).
51. Zuckerman, Stephen, and Dana Goin. "How much will Mediaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees." (2012). http://www.kff.org/medicaid/upload/8398.pdf.
52. Ibid.
53. "Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program." U.S. Department of Health and Human Services. Federal Register. Vol. 77, No. 215 (November 6, 2012).
54. Ibid.
55. Ensuring Access to Care in Medicaid under Health Reform. The Kaiser Commission on Medicaid and the Uninsured. May 2011. http://www.kff.org/healthreform/upload/8187.pdf
56. "Health Reform in Massachusetts Expanding Access to Health Insurance Coverage: Assessing the Results." Blue Cross Blue Shield of Massachusetts Foundation. May 2012. Retrieved on December 19, 2012 from https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/HealthReformAssessingtheResults.pdf
57. Long, Sharon K., and Karen Stockley. "The impacts of state health reform initiatives on adults in New York and Massachusetts." Health services research 46, no. 1p2 (2011): 365-387.
58. Ibid.
59. Long, Sharon K. "The Massachusetts Health Reform Survey." (2009).
60. Ibid.
61. Ensuring Access to Care in Medicaid under Health Reform. The Kaiser Commission on Medicaid and the Uninsured. May 2011. http://www.kff.org/healthreform/upload/8187.pdf
62. Health PolicyInstitute of Ohio. Access Basics (2012).
63. Ensuring Access to Care in Medicaid under Health Reform. The Kaiser Commission on Medicaid and the Uninsured. May 2011. http://www.kff.org/healthreform/upload/8187.pdf
64. Palmer, Jeremy D., Jill S. Herbold, Paul R. Houchens, and Andrew L. Naugle. Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange. Milliman, 2011. http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf.

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 XVIII 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 health insurance exchange is 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.