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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 $26,951 annually (see chart to the right).

2013 Federal Poverty Level (FPL) Guidelines
(by household size)

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

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

Source: *Federal Register*, January 24, 2013

The option that states have to expand Medicaid is unprecedented. Since the Medicaid program is a state-federal partnership, the federal government in the past 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 the impact on:

- Ohio's budget and economy
- Coverage, access and quality of care
- The private insurance market and providers

This brief is one of a series of publications HPIO is releasing 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 partnered with several organizations on more detailed, Ohio-specific research related to Medicaid expansion, with a preliminary analysis released in January 2013 and an updated analysis released in February 2013. In addition, the Health Policy Institute of Ohio (HPIO) will release its updated, biennial publication, "Ohio Medicaid Basics," in March 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" or "marketplace") 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 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).

As passed, the ACA required states, beginning in 2014, 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?

The Ohio Medicaid Expansion Study (see page 3) used two different approaches to estimate the health coverage, fiscal and economic effects of Medicaid expansion in Ohio. Both approaches yield the same conclusions. Medicaid expansion would:

- Increase Medicaid enrollment and, with it, state Medicaid costs
- Create net state budget gains for the next three and one and one-half biennia by generating state budget savings and state revenue that significantly exceed the state's cost of increased enrollment
- Cause state fiscal costs and gains that roughly balance out in fiscal year 2020 and thereafter (although the state is likely to continue receiving small net fiscal benefits from expansion)

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

The study, a partnership between the Health Policy Institute of Ohio (HPIO), The Ohio State University (OSU), Regional Economic Models, Inc. (REMI), and the Urban Institute, examines 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 the costs for newly eligible adults 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 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 addresses 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
- County revenue

Preliminary and final statewide findings were released in January 2013 and February 2013, respectively; local findings will be released in March 2013.

- Provide health coverage to hundreds of thousands of Ohio residents who would otherwise be uninsured
- Strengthen Ohio's economy by bringing in federal resources that have already been set aside for Medicaid expansion, creating tens of thousands of jobs within the state's borders
- Reduce health care costs for Ohio's employers and consumers
- Yield significant fiscal gains to Ohio's counties

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.[6] 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.[7] 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 if all provisions of the ACA are implemented, without Medicaid expansion, the number of uninsured in Ohio will decline by more than 530,000 by FY 2022. Adding Medicaid expansion would cause the number of uninsured to decline by an additional 450,000 Ohioans.

The Expansion Decision: Why there is variation among states

A common adage among health policy experts is, "If you've seen one state Medicaid program, you've seen one state Medicaid program." While federal statute sets broad guidelines for the Medicaid program, states are given considerable flexibility with regard to eligibility criteria, covered benefits, provider payment rates, and the use of managed care.

The state-specific design of the Medicaid program has a direct impact on the profiles of covered populations, the volume and types of covered services, service expenditures, and administrative costs. As such, the policy decision to expand or not expand Medicaid is very much dependent on a state's current Medicaid program design (prior to expansion).

Consider the states of Ohio and Wisconsin. Both states are led by Republican governors and both Medicaid programs cover roughly 20% of the state's total population. Governor Kasich of Ohio supports Medicaid expansion, while Governor Walker of Wisconsin opposes it. Given the differences between the two states' current Medicaid programs, the policy decision in each state is fundamentally different.

Because Ohio's existing Medicaid program covers less of the low-income population than Wisconsin's Medicaid program (BadgerCare), Ohio has more to gain by taking advantage of a largely federally-funded Medicaid expansion that extends coverage to uninsured parents and childless adults up to138%FPL.

BadgerCare already covers many people up to 200% FPL including limited coverage to childless adults. Governor Walker proposes lowering BadgerCare's eligibility for new adult enrollees to 100% FPL and eliminating the existing enrollment cap. Adults with incomes between 100% FPL and 138% FPL would no longer be covered by BadgerCare and instead could apply for federally-subsidized, private coverage through the state exchanges beginning in 2014.

In contrast, Ohio's Medicaid program currently covers parents up to 90% FPL, and there is no state-subsidized coverage option available for childless adults. By not expanding its Medicaid program, parents and childless adults with incomes below the poverty level would be left with no health care coverage and would be ineligible for exchange subsidies. As the ACA presumed these individuals would be covered by a Medicaid expansion, the law did not provide for subsidies for this group.

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. In addition to estimated costs resulting from the "woodwork" effect, the ACA will impact the state's budget even without an expansion. By FY 2022, Urban Institute estimates the ACA will result in net costs of $20 million, and Ohio State estimates net costs of $185 million.

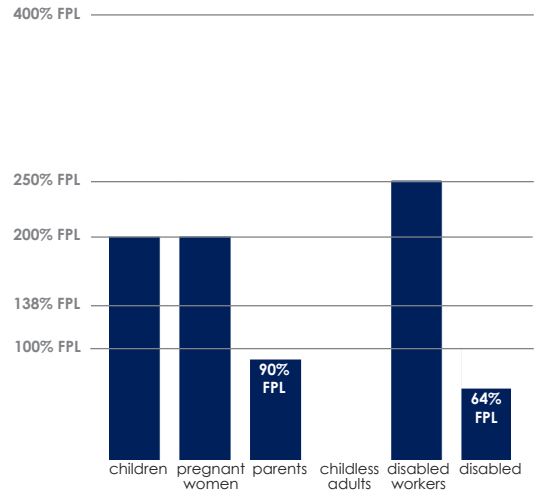
Even if Medicaid coverage is expanded, there will still remain a substantial number of uninsured Ohioans. According to estimates by the Urban Institute in the Expansion Study, over 630,000 Ohioans will remain uninsured. This is due to a variety of factors, including undocumented immigrants who are ineligible for coverage, individuals who qualify for but are not enrolled in Medicaid or CHIP, individuals who qualify for exchange subsidies but are not enrolled, and individuals who are ineligible for any assistance and who can not purchase unsubsidized health coverage.

How will Medicaid expansion impact providers?

Reduction in Disproportionate Share Hospital payments

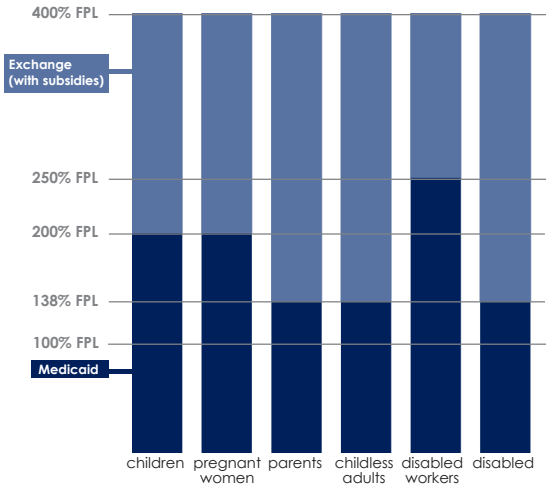
Separate from Medicaid, current federal law requires states to operate a Disproportionate Share Hospital (DSH) program that partially reimburses hospitals for uncompensated or free care provided to low-income and

Current Medicaid eligibility



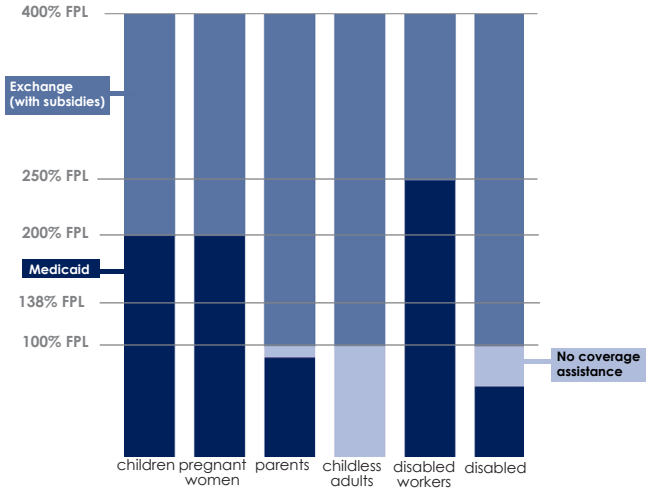
Subsidized health coverage eligibility for Ohioans in 2014

with ACA Medicaid expansion



Subsidized health coverage eligibility for Ohioans in 2014

without ACA Medicaid expansion



uninsured patients.[9] 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.[10] Many hospitals also provide charity care to low income individuals above 100% FPL.[11]

Because of 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.[12] 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.[13] 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.[14]

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.[15]

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.[21] Some of those moving from private coverage to Medicaid were underinsured, with inadequate coverage and high premiums, deductibles or copayments.[22] Underinsured individuals are more likely to apply for hospital charity care programs or have unpaid medical bills.[23] 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.[24]

However, Medicaid has a physician reimbursement rate that is lower than both private insurance and Medicare.[25] Consequently, a significant shift of Ohioans

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:[16]

- Not expanding Medicaid may increase insurance rates in the individual market.[17] 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.[18]
- 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.[19] 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.[20]

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 preventive care
- Experience fewer avoidable hospitalizations
- Have better health outcomes for a number of acute and chronic conditions [34]

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.

In 2012, there were 1,217,355 Ohioans living in primary care Health Professional Shortage Areas (HPSAs),[35] 671,531 of whom were estimated to be underserved.[36] Expansions of coverage under the ACA could contribute to this trend, at least in the short term.[37]

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.

Medicaid and Health Outcomes among Adults

Evidence regarding the impact of Medicaid coverage on health outcomes is varied and emerging. Some studies show that patients on Medicaid fare worse than those with private insurance[26,27,28] and, in some cases, worse than those with no insurance.[29] Other studies have demonstrated positive health outcomes related to Medicaid coverage.[30,31,32]

When reviewing available research, it is important to assess the following:

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

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

That is changing with the advent of the Oregon Health Study,[33] an ongoing randomized controlled study that compares adults who received Medicaid coverage as a result of a lottery, with those who did not. After the first year, researchers found that relative to uninsured low-income adults, new Medicaid recipients had less medical debt, used more health care, and reported better physical and mental health. To date, the only objective health measure is mortality, on which researchers were unable to detect an effect. Data from the second year will include physical health measures such as blood pressure, obesity, cholesterol, and blood sugar control. The results of the Oregon Health Study are specific to the study's population, plan, and health care environment.

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.[38] 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.[39] Consequently, it is primarily Medicaid's low payment rates that have deterred physician participation in Medicaid.[40] Notably, in 2011, only 72% of office-based physicians in Ohio accepted new Medicaid patients.[41]

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.[42] This increases payments for primary care services in Ohio by more than 70% in 2013.[43] 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.[44] While the rate increase applies only to certain providers who deliver primary care services[45] and is only for 2013 and 2014, states have the option to continue the rate increase beyond 2014 with state funds.[46]

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.[47]

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 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.[48]

Many safety net providers are struggling to maintain their operations and meet the increased demand for services caused by the economic downturn.[49] 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.[50]

Even if Ohio expands Medicaid coverage, more than 630,000 Ohioans may still be uninsured,[51] which means that services from safety net providers will still be needed to provide care for the uninsured.

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.[52] 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. Some adults in Massachusetts reported not being able to get an appointment in the early period of reform and experiencing delayed care.[53] 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.[54]

However, according to the Massachusetts Health Reform Survey, by 2010 a greater percentage of adults were receiving preventive care services and reporting a usual source of care.[55] 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.[56]

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 impacts of the ACA — both with and without a Medicaid expansion — be thoroughly examined prior to making the decision on whether Ohio should or should not expand the program.

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. 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
7. The Kaiser Family Foundation, State Health Facts. http://www.statehealthfacts.org/
8. Ohio is currently required by law to cover these eligible people if they enroll.
9. Graves, John A. "Medicaid Expansion Opt-Outs and Uncompensated Care." New England Journal of Medicine 367, no. 25 (2012): 2365-2367.
10. Ohio Hospital Association (OHA) Factsheet
11. Ibid.
12. 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.
13. Patient Protection and Affordable Care Act, Title III, Subtitle B, Part III, Section 3133.
14. Graves, John A. "Medicaid Expansion Opt-Outs and Uncompensated Care." New England Journal of Medicine 367, no. 25 (2012): 2365-2367.
15. Ibid.
16. American Academy of Actuaries, "Decision Brief: Implications of Medicaid Expansion Decisions on Private Coverage." September 2012.
17. Ibid.
18. 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
19. 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
20. 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.
21. Long, Sharon K., Stephen Zuckerman, and John A. Graves. "Are adults benefiting from state coverage expansions?." Health Affairs 25, no. 2 (2006): w1-w14.
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. 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).
24. 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.
25. 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.
26. LaPar DJ et al., Primary payer status affects mortality for major surgical operations. Annals of Surgery. 2010 Sep; 252(3): 544-51.
27. Kwok J et al., The impact of health insurance status on the survival of patients with head and neck cancer. Cancer. 2010 Jan; 116(2): 476-85.
28. Allen JG et al., Insurance status is an independent predictor of long-term survival after lung transportation in the United States. Journal of Heart and Lung Transplantation. 2011 Jan; 30(1): 45-53.
29. Kelz RR et al., Morbidity and mortality of colorectal carcinoma surgery differs by insurance status. Cancer. 2004 Nov; 101(10): 2187-94.
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31. Currie J, Gruber J. Saving babies: the efficacy and cost of recent expansions of Medicaid eligibility for pregnant women. Journal of Political Economy 1996;104:1263-96.
32. 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.
33. 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." National Bureau of Economic Research Working Paper 17190. 2011.
34. Institute of Medicine (US). Committee on the Consequences of Uninsurance. (2009). America's Uninsured Crisis: Consequences for Health and Health Care. National Academy Press.
35. 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.
36. The Kaiser Family Foundation, State Health Facts. http://www.statehealthfacts.org/
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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 — Also referred to as Medicare-Medicaid Eligible, or MME, 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.