North Carolina Council on Health Care Coverage: First Council Meeting

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December 4, 2020
Snapshot of Health Insurance Coverage in the United States, FY2019

Employer Sponsored Insurance 56%

Medicare 18%

Medicaid 17%

Individual Market 10%

Uninsured 8%

Who does Medicaid cover?

Mandatory Coverage Groups

- Low-income children
- Low-income pregnant women
- Families who would have qualified under 1996 Aid to Families with Dependent Children
- Aged, blind and disabled who qualify for social security income
- Low-income Medicare beneficiaries

Optional Coverage Groups

- Low income children and pregnant women at higher income levels
- Medically needy
- Medicaid expansion (adults with income up to 138% of FPL)

Who is covered under Medicaid Expansion?

**Low-income parents** (above current coverage levels and with income less than $2,498 per month for a family of 3)

- Low-wage workers (agriculture, child care, construction, etc.)
- Veterans and their families

**Low-income childless adults** (with income less than $1,436 per month for a single adult)

- Children who age out of Medicaid
- Women who would be covered if they were pregnant

Women who would be covered if they were pregnant
The large majority of Medicaid adults are already working or report potential barriers to work.

*Work Status & Barriers to Work Among Non-Dual, Non-SSI, Nonelderly Medicaid Adults, 2017*

- **Not Working Due to Retirement, Inability to Find Work, or Other Reason**: 7%
- **Not Working Due to School Attendance**: 7%
- **Not Working Due to Illness or Disability**: 11%
- **Not Working Due to Caregiving**: 12%
- **Working Full-Time**: 44%
- **Working Part-Time**: 19%

**Total = 23.5 million**

**Share Working: 63%**

Notes: Includes nonelderly adults (age 19-64) who do not receive Supplemental Security Income (SSI) and are not dual eligible. Working Full-Time is based on total number of hours worked per week (at least 35 hours). Full-time workers may be simultaneously working more than one job.

81% of the Medicaid population nationwide is enrolled in managed care and 47 states enroll 50% or more of their Medicaid population in managed care.

CMS 2016 Medicaid Managed Care Enrollment Summary. Comprehensive managed care includes acute, primary care and specialty benefits as well as PACE programs. Any type of managed care also includes limited benefit MCOs and PCCMs.

- 36 states enroll 50% or more of their Medicaid population in comprehensive managed care organizations (MCOs).
- An additional 11 states enroll 50% or more of their Medicaid population in limited benefit MCOs or primary care case management (PCCM).
- Only three states (WY, AK, CT) do not have any Medicaid managed care program.
Do you have a favorable/unfavorable opinion of Medicaid?

Figure 1

Large Majority Of The Public Have A Favorable View Of Medicaid

In general, do you have a favorable or an unfavorable opinion of Medicaid?

<table>
<thead>
<tr>
<th></th>
<th>Very favorable</th>
<th>Somewhat favorable</th>
<th>Somewhat unfavorable</th>
<th>Very unfavorable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>39%</td>
<td>36%</td>
<td>12%</td>
<td>7%</td>
</tr>
<tr>
<td>Democrats</td>
<td>53%</td>
<td>31%</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Independents</td>
<td>37%</td>
<td>39%</td>
<td>12%</td>
<td>8%</td>
</tr>
<tr>
<td>Republicans</td>
<td>27%</td>
<td>38%</td>
<td>18%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Since 2014, 38 states and DC have adopted Medicaid expansion.

States continue to shape their programs and, to date, no state has decided to stop their expansion.

Two states (MO & OK) adopted expansion through 2020 ballot measures but have not yet implemented
Nonelderly Uninsured Rate, 2013-2019

Note: State Medicaid expansion status as of Jan 1, 2017. Data include persons under age 65.

United States
Expansion States
Non-expansion States

Uninsured Rates among the Nonelderly by State, 2019

United States: 10.9%

NOTE: * Indicates a statistically significant change from 2018 to 2019 at the p<0.05 level. Includes nonelderly individuals ages 0 to 64.

Figure 8
Barriers to Health Care among Nonelderly Adults by Insurance Status, 2019

<table>
<thead>
<tr>
<th>Reason</th>
<th>Uninsured</th>
<th>Medicaid/Other Public</th>
<th>Employer/Other Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did Not See Doctor/Health Care Professional</td>
<td>41.5%</td>
<td>11.9%</td>
<td>14.6%</td>
</tr>
<tr>
<td>No Usual Source of Care</td>
<td>40.8%</td>
<td>11.5%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Postponed Seeking Care Due to Cost</td>
<td>32.1%</td>
<td>10.0%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Went Without Needed Care Due to Cost</td>
<td>30.2%</td>
<td>9.5%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Delayed Filling or Did Not Get Needed</td>
<td>19.8%</td>
<td>12.4%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Prescription Drug Due to Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Includes nonelderly individuals ages 18 to 64. Includes barriers experienced in the past 12 months. Respondents who said usual source of care was the emergency room were including among those not having a usual source of care. All Medicaid/Other Public and Employer/Other Private are statistically different from Uninsured at the p<0.05 level.


Medicaid Expansion Cost Projections

States rely on key data points about the newly eligible Medicaid population to make accurate state budget projections, including:

- Prior to 2014, little data were available on these metrics. Some states under and overestimated the impact of Medicaid expansion on state budgets.
- Better information is now enabling more recently expanding states to more accurately predict the fiscal impacts of Medicaid expansion.
More than half of Medicaid spending in expansion states is on the Elderly and Disabled Populations.

Medicaid Spending in Expansion States by Population, FY 2014

Enrollment
- Disabled 13%
- Elderly 9%
- Adults 40%
- Children 39%

Spending
- Disabled 37%
- Elderly 19%
- Adults 25%
- Children 18%

Sources of Funding for Medicaid Expansion

• Sources of funding for the Medicaid expansion are similar to those for the regular Medicaid program.

• Medicaid expansion has generated state savings by offsetting costs related to behavioral health services, the criminal justice system, SSI program costs, and by covering populations previously funded at the regular federal match rate.

<table>
<thead>
<tr>
<th>Non-federal share (10%)</th>
<th>Federal share (90%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider taxes and fees</td>
<td>Hospital taxes and fees</td>
</tr>
<tr>
<td>Medicaid and other state program savings</td>
<td>State general funds</td>
</tr>
<tr>
<td>Health plan taxes</td>
<td>Other taxes and local sources*</td>
</tr>
</tbody>
</table>

Note: “Other” includes cigarette taxes (IN), increases in drug rebates (KY), local government funds (IL), and “other revenue” (NH).

Impacts of Medicaid Expansion: Improving Access

**Coverage**
- Medicaid expansion has resulted in significant coverage gains among low-income and vulnerable populations and reductions in disparities.
- Several studies have shown especially large coverage gains for low income workers and individuals with mental illness and substance use disorders.

**Access to Care**
- Multiple studies have demonstrated increased utilization of preventive care for a range of conditions including cancer, diabetes, behavioral health, and heart disease.
- One study found increases in primary care appointment availability and another found an increase in providers accepting new patients.
- Many studies conclude that providers have expanded capacity or participation in Medicaid (including for providing medications for the treatment of opioid use disorders).
- National studies have shown reductions in Marketplace premiums in expansion states compared to non-expansion.

**Affordability**
- Multiple studies show large declines in out of pocket costs, delays in seeking care due to cost, medical debt among Medicaid expansion enrollees, and disparities in affordability.
- Medicaid expansion has resulted in significant declines in uncompensated care for hospitals, clinics, and other providers.

Impacts of Medicaid Expansion: Health Outcomes

- Multiple studies show increases in self-reported health and positive health behaviors
- Studies have found associations with reductions in mortality, at the population level and for particular health conditions such as cardiovascular illness and end-stage renal disease
- Low-income individuals in Kentucky and Arkansas reported a 23 percentage point increase in “excellent” self-reported health from 2013 to 2016.
- Mean infant mortality rates declined in Medicaid expansion states but rose slightly in non-expansion states from 2014 to 2016.

- Improvements in self-reported mental health
- A 2020 study found that expansion was associated with a 6% lower rate of opioid overdose deaths
- Improvements in access to medications and services for the treatment of mental health and substance use disorders
- Increases in access to treatment for opioid use disorders and no increase in opioid prescribing rates
- Kentucky saw 300 new behavioral health providers enroll with Medicaid in 2014 and provided substance use disorder services to 13,000 members

KFF, The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature review, March 2018; The Effects of Medicaid Expansion Under the ACA, State Health & Value Strategies, September 2018; Sommers et. al., Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults, Health Affairs 2017;36(6):1119-28.
Impacts of Medicaid Expansion: Economy

- Ohio Medicaid expansion enrollees reported that Medicaid enrollment made it easier to seek employment and continue working.
- Medicaid expansion created 31,074 additional jobs in Colorado as of FY2015-2016, 39,000 additional jobs in Michigan in 2016, and will create an estimated 40,000 jobs in Kentucky through SFY2021 with an average salary of $41,000.
- National studies show that expansion support the ability to work or seek work and is associated with increases in labor force participation and employment.

- Expansion has also been associated with decreases in poverty rates and food insecurity.
- Pennsylvania saw a $2.2 billion increase in economic output and $53.4 million increase in state tax revenue.
- A 2017 study of Michigan’s expansion found that personal income increased by more than $2 billion per year, yielding over $145 million in new state tax revenue.

- Montana’s state budget savings through state fiscal year 2017 exceed $36 million as a result of Medicaid expansion.
- As of March 2018, Medicaid expansion in Louisiana created nearly 19,000 jobs and enhanced state revenues by more than $100 million.
Impacts of Expansion on Rural Communities

- Increases in coverage
- Improved operating margins for rural hospitals
- Improved hospital financial performance and reductions in rural hospital closure

*Source: GAO analysis of Department of Health and Human Services (HHS) and HHS-funded data. | GAO-18-934

Note: Hospitals were defined as general acute care hospitals in the United States, and a hospital closure as a cessation of inpatient services. Rural was defined using the Federal Office of Rural Health Policy's definition (areas in (i) a non-metropolitan county, (ii) a metropolitan county, but with a Rural-Urban Commuting Area code of 4 or higher, or (iii) one of 132 large and sparsely populated census tracts with a Rural-Urban Commuting Area code of 2 or 3). Medicaid expansion status is as of April 2018.*
Medicaid is the largest funding source for the treatment of Opioid Use Disorders.

Overall, 34% of Substance Use Treatment is covered by Medicaid, 44% by Private, and 32% by Uninsured. Medicaid's Role in Addressing the Opioid Epidemic (2019).
Medicaid’s Role in Responding to COVID-19

Medicaid enrollment is increasing amid the COVID-19 pandemic. Nationally, enrollment has increased by 4.3 million or 6.1% from Feb 2020 to July 2020.

The five states with the highest and lowest percentage increase in enrollments represent a mix of expansion and non-expansion states.

<table>
<thead>
<tr>
<th>State</th>
<th>Percentage Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kentucky</td>
<td>13.4%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>12.9%</td>
</tr>
<tr>
<td>Nevada</td>
<td>11.3%</td>
</tr>
<tr>
<td>Utah</td>
<td>10.2%</td>
</tr>
<tr>
<td>Missouri</td>
<td>10.1%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>2.4%</td>
</tr>
<tr>
<td>California</td>
<td>2.7%</td>
</tr>
<tr>
<td>Alabama</td>
<td>3.7%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>3.7%</td>
</tr>
<tr>
<td>Nebraska</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

*Source: Kaiser Family Foundation Analysis of Recent National Trends in Medicaid and CHIP Enrollment (Oct 2020).*
Medicaid Expansion’s Role in Responding to COVID-19

Projected Federal Medicaid and CARES Act Funding per Person, Expansion States vs. Nonexpansion States

Medicaid Expansion Boosts Coverage for Low-Income Essential Workers

Note: Figures exclude states that are projected to receive the minimum CARES Act allocation ($1.25 billion). The "expansion" category excludes Virginia, which expanded in 2019 but currently lacks sufficient data on expansion group expenditures and the new uninsured rate.
Contact

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North Carolina Medicaid Overview

Dave Richard
Deputy Secretary, NC Medicaid

December 4, 2020
North Carolina Medicaid
Improving the health and quality of life for families

Supporting millions of North Carolina families for 50 years.
<table>
<thead>
<tr>
<th>Group</th>
<th>Monthly Income</th>
<th>Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Adults &gt; 65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People with blindness</td>
<td>100% of Poverty Level</td>
<td>100% of Poverty Level</td>
</tr>
<tr>
<td>People with disabilities</td>
<td>1 - $1,041</td>
<td>1 - $12,760</td>
</tr>
<tr>
<td>*Asset limits also apply</td>
<td>2 - $1,410</td>
<td>2 - $17,240</td>
</tr>
<tr>
<td>People with blindness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People with disabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Asset limits also apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents/caretakers of children &lt;18, individuals aged 19 and 20</td>
<td>~42% of Poverty Level</td>
<td>~42% of Poverty Level</td>
</tr>
<tr>
<td></td>
<td>1 - $434</td>
<td>1 - $5,360</td>
</tr>
<tr>
<td></td>
<td>2 - $569</td>
<td>2 - $7,240</td>
</tr>
<tr>
<td></td>
<td>3 - $667</td>
<td>3 - $9,120</td>
</tr>
<tr>
<td>Children &lt;6</td>
<td>210% of Poverty Level</td>
<td>210% of Poverty Level</td>
</tr>
<tr>
<td></td>
<td>1 - $2,186</td>
<td>1 - $26,800</td>
</tr>
<tr>
<td></td>
<td>2 - $2,960</td>
<td>2 - $36,200</td>
</tr>
<tr>
<td></td>
<td>3 - $3,733</td>
<td>3 - $45,610</td>
</tr>
<tr>
<td>Children &gt;6</td>
<td>Medicaid 133% of Poverty Level</td>
<td>Medicaid 133% of Poverty Level</td>
</tr>
<tr>
<td></td>
<td>1 - $1,385</td>
<td>1 - $16,970</td>
</tr>
<tr>
<td></td>
<td>2 - $1,875</td>
<td>2 - $22,930</td>
</tr>
<tr>
<td></td>
<td>3 - $2,365</td>
<td>3 - $28,890</td>
</tr>
<tr>
<td></td>
<td>Health Choice 211% of Poverty Level</td>
<td>1 - $26,928</td>
</tr>
<tr>
<td></td>
<td>1 - $2,244</td>
<td>2 - $36,384</td>
</tr>
<tr>
<td></td>
<td>2 - $3,032</td>
<td>3 - $45,840</td>
</tr>
<tr>
<td></td>
<td>3 - $3,820</td>
<td></td>
</tr>
<tr>
<td>Non-disabled childless adults aged 19-64</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
Medicaid Enrollment and Service Expenditures by Group (Full Medicaid)

- **Beneficiaries**:
  - Families and Children: 75%
  - People with Disabilities: 17%
  - Older Adults: 8%

- **Service Expenditures**:
  - Families and Children: 36%
  - People with Disabilities: 47%
  - Older Adults: 17%
NC MEDICAID COVID-19 RESPONSE ACCOMPLISHMENTS

Member Experience and Access to Quality Care
- 175,234 COVID-19 tests covered by Medicaid
- 3565 Members enrolled in optional COVID-19 testing group
- 1.2M Medicaid eligibility extensions conducted (673k individual cases), 1.2M letters mailed to members
- 656K Enrollment applications processed since March 1
- 135 Telehealth flexibilities implemented, which spanned 482 codes
- 1,582,470 Telehealth claims processed
- 272 PA & Service Limits waivers were put in place
- Total of 119,830 Pharmacy mailing and delivery fees paid, $326,611.5 paid to Providers
- 150+ Service Tickets & FMRs completed
- 203 Individual flexibilities implemented across LME-MCOs
- 26 LME-MCO ILOS: 23 of which are approved

Provider Enablement and Financial Support
- 139 Disaster applications processed
- 94 Provider closures managed, and 228 negatively impacted members assisted with access to care
- Reverification due dates extended for 8,292 providers (based on report received Oct. 27, 2020)
- Effectuated over ~$1 Billion in rate changes supporting providers across ~210 rate FMRs
- Over $5.5 Million in Cares Act Funding distributed to ~200 congregate care providers to support COVID-19 testing
- ~$50 Million in advance payments issued to Outbreak providers

Authority
- 21 Waiver documents submitted to CMS; 20 Waivers approved; 1 under review
- 246 Flexibilities sent to CMS; 192 Approved; 6 Pending CMS response
- 328 CMS FAQs Follow-ups received. 325 complete; 3 in review with respective workstreams

Monitoring and Evaluation
- 17 Clinical, financial and enrollment dashboards developed
- 17 Telehealth uptake analysis visualizations developed
- 26 Telehealth evaluation metrics delivered
- 34 LTSS evaluation questions developed

Communication and Education
- 114 Provider webinars hosted with 49,398 attendees
- 140 COVID-19 Special Medicaid Bulletins published
- 113 NCTracks blasts to providers covering 126 topics
- 1,088 Inquiries received through COVID-19 Mailbox, 93% addressed
- Since the MCC went remote: 157,692 calls offered; 154,320 calls handled, 2% abandonment rate, 28 second average wait time
- COVID-19 Triage Plus Line enabled with CCNC, 55,061 calls received since launch

Process Efficiencies and Automation
Streamlined FAQs/Inquiries Management
- 1,570 Incidents opened since March 27
- 1,508 Incidents resolved

Knowledge Management
- 162 FAQs and 139 Bulletins incorporated since launch April 24

Circuit Breaker Process
- Two rounds of evaluation complete
- 386 Flexibility groups evaluated
- 44 were recommended to continue
- 68 were recommended to continue with changes

Facilities and Infrastructure
- 520+ Medicaid staff enabled to work remotely
- 242 Devices issued to support remote work
NC Medicaid Fiscal Year-End Financial Position ( Appropriations)
North Carolina’s Vision for Medicaid Transformation

“To improve the health of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses both the medical and non-medical drivers of health.”
**Auto Enrollment (AE)**
- Beneficiaries that have not selected a PHP are auto enrolled with a PHP
- PHPs begin mailing ID cards

**Managed Care Launch**
- 07/01/21

**End of Choice Period**
- 09/29/21

**January '21**
- Soft Launch
  - Distribute Enrollment Packets to Beneficiaries
  - Enrollment Broker (EB) Call Center Go-Live
  - EB Enrollment Web Page Go-Live
  - EB Mobile App Launch

**Open Enrollment**
- Formally Begins: 03/15/21
- Conclude State-wide Open Enrollment: 05/14/2021

**Managed Care**
- Launch: 07/01/21

**90-DAY CHANGE PERIOD**
- Beneficiaries can change PHPs without cause

**Medicaid Transformation Timeline**
- Begin State-wide Open Enrollment: 03/01/21
Uninsurance in North Carolina
Health Insurance Coverage

1.2 million uninsured residents in North Carolina

Source: Census Bureau, American Community Survey data, 2019
How does coverage for 19-64 YOs in NC compare to US, Expansion states?
NC: 6th highest uninsured rate in 2019

Note these rates are based on pre-pandemic unemployment levels.
Uninsured rate may be as high as 20% in NC currently.

Source: 2019 Census American Community Survey
Who are the Uninsured

Lower income are more likely to be uninsured

138% FPL = $36,156 for family of 4 in 2020

Percent of uninsured by income category (FPL)

- Less than 50% FPL: 24.3%
- 50-100% FPL: 17.6%
- 100-150% FPL: 17.3%
- 150-200% FPL: 18.1%
- 200+% FPL: 7.8%

Medicaid Expansion
100 – 138% FPL

34% of the NC uninsured have income < 138% FPL
28% of workers do not have access to employer medical benefits.

Sample Industries with Low-Income Uninsured Workers (Pre-Pandemic)

- **Grocery Workers**
  - 19% Uninsured
  - Annual Income: $21,680
  - 2018 Employer Insurance: 52%

- **Nursing Home/Home Health**
  - 14%/19% Uninsured
  - Annual Income: $33,280/$29,952
  - 2018 Employer Insurance: 57%/39%
  - (Direct care workers average $10/hour)

- **Clothing Store Workers**
  - 14% Uninsured
  - Annual Income: $19,800
  - 2018 Employer Insurance: 55%

- **Hotel / Lodging Workers**
  - 28% Uninsured
  - Annual Income: $24,450
  - 2018 Employer Insurance: 40%

- **Restaurant Workers**
  - 28% Uninsured
  - Annual Income: $17,160
  - 2018 Employer Insurance: 40%

- **Hair Cutters**
  - 20% Uninsured
  - Annual Income: $28,320
  - 2018 Employer Insurance: 37%

- **Child Day Care Workers**
  - 20% Uninsured
  - Annual Income: $22,360
  - 2018 Employer Insurance: 52%
Expansion States Have Lower Percent of Uninsured Adults

Uninsured adults 19-64

- North Carolina: 23% (2013), 16% (2017)
- Kentucky: 21% (2013), 7% (2017)
- West Virginia: 21% (2013), 9% (2017)
- Arkansas: 24% (2013), 12% (2017)

Source: Census Bureau, American Community Survey data
Who Would be Eligible for Medicaid Expansion in North Carolina?

- More than half of uninsured low-income adults are under 40.

Employment Industries of Uninsured

- Most are employed.
- High uninsurance rates in hospitality, retail, and manufacturing.

Race / Ethnicity

- Uninsured Adults In North Carolina Family Status
  - 52% Have Children 0-17
  - 48% No Children

Gender

- Uninsured low-income adults are primarily women.

Family

- One in three uninsured eligible are parents of children under 18.
North Carolina hospitals provided approximately $1,825,000,000 in uncompensated care in 2019 (Plus another $1.6 billion in losses from Medicaid and Medicare)

Source: September 2020 Medicare Cost Reports
A higher percentage of people in rural areas would be eligible for Medicaid expansion in North Carolina.
• Rural residents are **40% more likely** to be uninsured and eligible for Medicaid expansion

• Prior studies have shown that Medicaid expansion is associated with **improved hospital financial performance** and reductions in hospital closure

• **11 rural hospitals have closed** in North Carolina since 2005. Many others have cut key services.

• There are 6 rural hospitals that the Sheps Center classifies as having high financial risk – **these hospitals serve communities of about 180,000 people**.

• Losing the only hospital in a county implies a **decrease of about $1,300 dollars in per capita income**
Veterans and their Families

- North Carolina has 730,357 Veterans
- Only 338,5050 of those receive care through the VA
- Even if a Veteran receives health care through the VA their families may remain uninsured
- Veterans' uninsurance rate decreased 4.3 percentage points in expansion states.
- Medicaid Expansion could help approximately 14,000 additional North Carolina Veterans gain health coverage

Source: Robert Wood Johnson and Urban Institute Analysis
Medicaid expansion would reduce the number of North Carolinians without insurance

- People in North Carolina who would be eligible for Medicaid Expansion are more likely to be younger, working for essential industries, and include many families
- Medicaid Expansion would help rural residents, strengthen rural hospitals, and financially benefit rural communities
- More than 200,000 uninsured employees will have health insurance helping many small and essential business maintain a healthy workforce
Ohio’s Medicaid Expansion

Greg Moody, Executive in Residence
moody.67@osu.edu
December 4, 2020
2010 Ohio Medicaid was growing more than 10% annually and the state had an $8 billion budget deficit.

Ohio Medicaid was growing less than 3% annually with $2 billion in the rainy-day fund.

- Restructure and rebid Medicaid managed care
- Prioritize home and community based services
- Rebuild behavioral health system capacity
- Modernize technology infrastructure
- Engage partners to pay for value instead of volume
- Increase access to comprehensive primary care
- Reward value in high cost episodes of care
- Extend Medicaid coverage
The Commonwealth Fund 2020 Scorecard on Overall State Health System Performance

Notes: States are arranged in rank order from left (best) to right (worst), based on their overall 2020 Scorecard rank. The 2020 Scorecard rank reflects data generally from 2018, prior to the COVID-19 pandemic MO and OK expanded Medicaid in 2020. Ohio’s 2020 rank of 28th best performance represents a +6 change from baseline.
The Commonwealth Fund 2020 Scorecard on Overall State Health System Performance

The 13 states that have so far chosen not to expand Medicaid are circled

Notes: States are arranged in rank order from left (best) to right (worst), based on their overall 2020 Scorecard rank. The 2020 Scorecard rank reflects data generally from 2018, prior to the COVID-19 pandemic. MO and OK expanded Medicaid in 2020. Ohio’s 2020 rank of 28th best performance represents a +6 change from baseline.
Ohio Medicaid Income Eligibility Levels prior to January 2014

In 2013, one million Ohioans lacked affordable health insurance.

Federal Income Eligibility Levels after January 2014

Private Insurance

Federal Health Insurance Exchange

Optional Medicaid Expansion to 138% of poverty

Ohio Medicaid

Federal Income Eligibility Levels after January 2014

- More than half work ≥ 20 hours
- 700,000 likely to enroll in Medicaid
- 257,000 with a serious health condition that prevents/limits work
- 172,000 need behavioral health care
- 126,000 age 55 or older
- 96,000 parent caretakers
- 26,000 uninsured veterans

Counties with 10,000+ Medicaid Expansion-eligible residents

SOURCE: Ohio Department of Medicaid, Managed Care Enrollment and Eligibility Report.
Medicaid Expansion-eligible residents by county

SOURCE: Ohio Department of Medicaid, 2018 Medicaid Group VIII Assessment (August 2018).
Cultivate a Broad and Transparent Coalition

*Obviously* ...

- Health plans, hospital systems, and other providers
- Legal aid and other patient and family advocates

*More compelling* ...

- Rural hospitals
- Sheriffs (untreated addiction in jails)
- Right to Life (Hyde Amendment)
- Chambers of Commerce (cost shift)
- Veterans and their families
- Families impacted by addiction

- Ohio created an informal, come-one-come-all Coalition that enabled instant communication.
- The state team shared the same information with everyone at the same time, including the press.
Medicaid expansion increased Ohio’s behavioral health system capacity 60 percent over five years.

SOURCE: Ohio Departments of Medicaid and Mental Health and Addiction Services (January 2017).
20% Increase in Medicaid Primary Care Practitioners since 2013

SOURCE: Ohio Department of Medicaid, 2018 Medicaid Group VIII Assessment (August 2018).
Non-Medicaid coverage remained stable throughout expansion

Annual Percentage Increase in Ohio Medicaid Spending Per Member

SOURCE: Ohio Legislative Service Commission Budget Central for Ohio Medicaid actual total spending and total caseloads to calculate per member per month growth.

Ohio Medicaid Expansion

2012: $659, -4.7%
2013: $688, +4.4%
2014: $660, -4.1%
2015: $693, +5.1%
2016: $689, -0.6%
2017: $689
## Ohio’s Share of Medicaid Expansion Costs (in millions)

<table>
<thead>
<tr>
<th></th>
<th>SFY 2019</th>
<th>SFY 2020</th>
<th>SFY 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Group VIII cost</strong></td>
<td>$4,814</td>
<td>$5,074</td>
<td>$5,348</td>
</tr>
<tr>
<td><strong>Match rate (state fiscal year)</strong></td>
<td>6.5%</td>
<td>8.5%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Ohio share of Group VIII cost</strong></td>
<td>$313</td>
<td>$431</td>
<td>$534</td>
</tr>
<tr>
<td>Drug rebates</td>
<td>($43)</td>
<td>($58)</td>
<td>($72)</td>
</tr>
<tr>
<td>Corrections medical expense savings</td>
<td>($18)</td>
<td>($18)</td>
<td>($18)</td>
</tr>
<tr>
<td>Enhanced FMAP for hospital UPL</td>
<td>($40)</td>
<td>($38)</td>
<td>($36)</td>
</tr>
<tr>
<td>MCO member-month tax</td>
<td>($198)</td>
<td>($198)</td>
<td>($198)</td>
</tr>
<tr>
<td>MCO HIC tax</td>
<td>($45)</td>
<td>($48)</td>
<td>($50)</td>
</tr>
<tr>
<td><strong>Net Impact on Ohio</strong></td>
<td>($31)</td>
<td>$72</td>
<td>$161</td>
</tr>
<tr>
<td><strong>Effective match rate</strong></td>
<td>0%</td>
<td>1.4%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

**SOURCE:** Ohio Office of Budget and Management analysis (July 2018).
General findings ...

- a large decline in the uninsured rate to the lowest level on record;
- most enrollees (89%*) were uninsured prior to obtaining Medicaid coverage;
- better access to care was associated with a reduction in unmet medical needs;
- high-cost emergency department use decreased (17%);
- many enrollees (27%*) detected previously undiagnosed chronic conditions;
- health status improved for many (31%);
- more than one third (37%) quit smoking and said Medicaid helped them quit;
- many enrollees (25%) screened positive for depression or anxiety;
- easier to work (84%) or if unemployed to look for work (60%);
- most enrollees (49%) said it was easier to pay for necessities like food and rent;
- the percentage of enrollees with medical debt fell by half (from 56% to 31%*).
Medicaid expansion has benefitted enrollees by ...

- facilitating continued employment, new employment, and job seeking;
- increasing primary care and reducing emergency department use;
- lessening medical debt and financial hardship;
- improving mental health;
- assisting in addressing unhealthy behaviors such as tobacco use; and
- enabling enrollees to act as caregivers for family members.

Compared to 2016 assessment, a higher percentage of 2018 enrollees ...

- are now employed;
- access primary care providers and use emergency department services less;
- report better mental health; and
- are optimistic about their individual functioning.

SOURCE: Ohio Department of Medicaid, 2018 Medicaid Group VIII Assessment (August 2018).
Work is the most common reason for leaving expansion coverage

- For many enrollees, Group VIII is a stepping-stone to greater economic self-sufficiency.
- Only about one third (37%) of individuals who ever enrolled have maintained continuous Group VIII coverage.
- Most who leave Group VIII say it’s because they got a job (71%) or other coverage (49%).
- For those who return to Group VIII, more than half (54%) say it’s because they lost a job.

Correcting Misconceptions

“Ohio’s newly eligible enrollment is 60% over what had been projected.”
In fact, enrollment is 13% below original projections and stable.

*Ohio’s expansion “costs per enrollee are surging 35% annually.”*
In fact, costs are growing at a manageable 3.3% annually.

*Disabled Ohioans are stuck on Medicaid waiting lists because expansion shoved them to “the back of the line … without the care they need.”*
In fact, at the same time Ohio expanded Medicaid the state added 22,000 disability waivers and eliminated waiting lists.

Reflecting on Ohio’s path to Medicaid expansion ...

- Get organized and commit leadership
- Cultivate a broad coalition of stakeholders
- Look at the evidence in other states
- Reduce impact on the state budget
- Use expansion to achieve other reform priorities
- The trend is only in one direction ...

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