Policy Matters Ohio

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Medicaid Works

Good outcomes, good for Ohio

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Ohio legislators have taken Medicaid expansion out of the budget, but keep talking about it. That's good, because expanding Medicaid would be good for Ohio and good for Ohioans. In this issue brief, we look at studies of Medicaid quality.

Medicaid expansion benefits
How can we reduce suffering and boost productivity?
Expand access to preventive health care.
How can we get people more access to health care?
People without health coverage have 110 times more trouble seeing a specialist than people with Medicaid.
How can we improve mental health?
Medicaid covers mental health services; depression has declined where Medicaid has been expanded.
Who loses health care if Medicaid is not expanded?
The cost of uncompensated care endangers small hospitals in rural areas.

Medicaid helps Ohioans gain access to doctors

A national study found uninsured people have much greater difficulty gaining access to needed care than those with Medicaid.[1] The 2008 Ohio family health survey found that in Ohio, uninsured people were three times as likely to report lack of needed care than those with Medicaid coverage; the same share reported delays in obtaining the care they needed. [2]

Preventive care can improve lives

Medicaid provides access to preventive and regular care, which reduces suffering and death rates of chronic illness. Not only can screenings and precautionary steps often prevent onset of disease (e.g., breast cancer, diabetes, and cardiovascular disease) but early diagnosis and treatment can significantly increase chances of leading a healthy and productive life. A study of Medicaid patients found expansions of Medicaid eligibility in three states were associated with a significant decrease in mortality during a 5-year follow-up period, as compared with neighboring states without Medicaid expansions. Mortality reductions were greatest among adults between the ages of 35 and 64 years, minorities, and residents of poor counties.[3] The estimated decrease in mortality was 6.1 percent.[4]

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[1] Nakela Cook et al. "*Access to Specialty Care and Medical Care Services in Community Health Centers*." Health Affairs. Volume 26, no 5 (2007): 1459-1468 http://content.healthaffairs.org/content/26/5/1459/T2.large.jpg.

[2] William Hayes, Testimony to the Ohio Senate Subcommittee on Medicaid Finance, May 7, 2013 at http://bit.ly/10uhmlv

[3] Dr. Benjamin D. Sommers, Dr. Katherine Baicker & Dr. Arnold M. Epstein, *Mortality and access to care among adults after state Medicaid expansion*," The New England Journal of Medicine (September 13, 2012) at http://bit.ly/LTcBeF.

[4] "Our estimate of a 6.1% reduction in the relative risk of death among adults is similar to the 8.5% and 5.1% population-level reductions in infant and child mortality, respectively, as estimated in analyses of Medicaid expansions in the 1980s. Our results correspond to 2,840 deaths prevented per year in states with Medicaid expansions, in which 500,000 adults acquired coverage. This finding suggests that 176 additional adults would need to be covered by Medicaid in order to prevent 1 death per year." – see Sommers, Baicker & Epstein, Op.Cit.

Preventive care is long term, but provides short-term benefits too

A recent, limited study of Oregon's expansion of Medicaid coverage sheds light on the potential beneficial effects of Medicaid expansion, particularly with mental illness. Even on a short-term (two-year) basis, access to Medicaid was found to increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.[5] These benefits occurred with no negative effects, such as increases in emergency-room use.

Ohio Medicaid gets high marks

The relative strength of Ohio's program is shown by a 50-state study released in early May 2013. The report compared the quality of hospital care between patients with Medicaid and those with private insurance by studying three medical conditions. While it found substantial variation in Medicaid outcomes across the states, the report found only small overall differences between Medicaid and private pay. For Ohio, the study found no difference between Medicaid and private pay for two conditions and only a 1 percentage point difference for the third. The study found that Ohio's scores were always above the national Medicaid average.[6]

Medicaid expansion offers public health benefits

The public health benefits of expanded Medicaid translate directly to public safety and security. Access to care reduces the spread of disease by providing a cure or reducing infectiousness. For example, continuous and comprehensive treatment of HIV not only improves the health of the individual, but also reduces the likelihood of transmitting the virus by 96 percent.[7]

Medicaid expansion protects health care access in rural areas

The federal Affordable Care Act incrementally reduces federal payments to hospitals (known as disproportionate share hospital funds, or DSH), anticipating that increased access to both Medicaid and private insurance will reduce the amount of uncompensated care that hospitals provide.[8] Thus, hospitals in states with limited Medicaid coverage will face severe deficits as they continue to treat a high volume of uninsured patients. Without federal reimbursements for this care, hospitals will pass costs onto covered private-insurance patients; small hospitals (e.g., in rural areas) will not be able to offset these costs, and may be forced to close, leaving entire communities without access to care.[9] According to a new rule governing the funding of DSH published by the Center for Medicare and Medicaid, our state's safety net hospitals could face more than $23.4 million in cuts in 2014 to DSH funds. The cuts will grow deeper in the years that follow; by 2018, DSH cuts will total 40 percent nationally.[10]

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[5] Dr. Katherine Baicker et.al, *The Oregon Experiment: Effects of Medicaid on Clinical Outcomes*, The New England Journal of Medicine (May 2, 2013) at http://bit.ly/11CbFcw.

[6] William Hayes, Op.Cit. , (drawing on Joel S. Weissman, Christine Vogeli, and Douglas E. Levy. "The Quality of Hospital Care for Medicaid and Private Pay Patients." *Medical Care.* May 2013; 51:389-395.)

[7] Myron S. Cohen et al, *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*, The New England Journal of Medicine (August 11, 2011) at www.nejm.org/doi/full/10.1056/NEJMoa1105243.

[8] Hospitals are required by law to stabilize any patient in need, regardless of ability to pay.

[9] Harvard Law School Center for Health Law & Policy Innovation, *Expanding Medicaid under the Affordable Care Act: Where do States Stand Today?* at http://hvrd.me/QEndow.

[10] Centers for Medicare and Medicaid Services, Details for: Medicaid state disproportionate share hospital allotment reductions proposed rule http://go.cms.gov/17XSLvF.

Additional resources

Studies of Medicaid, Medicaid expansion and insurance availability

United States Government Accountability Office. "Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance," November 2012. Retrieved at www.gao.gov/assets/650/649788.pdf.

> *"Over two-thirds of states reported challenges to ensuring enough Medicaid providers to serve beneficiaries—including dental and specialty care providers. States cited Medicaid payment rates and a general shortage of providers as adding to the challenge. To attract new providers, over half the states reported simplifying administrative requirements or increasing payment rates.*
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> *In calendar years 2008 and 2009, less than 4 percent of beneficiaries who had Medicaid coverage for a full year reported difficulty obtaining medical care, which was similar to individuals with full-year private insurance; however, more Medicaid beneficiaries reported difficulty obtaining dental care than those with private insurance. Beneficiaries with less than a full year of Medicaid coverage were almost twice as likely to report difficulties obtaining medical care as those with full-year coverage. Medicaid beneficiaries reported delaying care for reasons such as long wait times and lack of transportation."*

Nakela Cook et al. "Access to Specialty Care and Medical Care Services in Community Health Centers." *Health Affairs.* Volume 26, no 5 (2007): 1459-1468.
Retrieved at http://content.healthaffairs.org/content/26/5/1459/T2.large.jpg.

> *This study evaluates access to specialty health services for patients receiving care in Community Health Centers (CHCs), using a survey of medical directors of all federally qualified CHCs in the United States in 2004. Respondents reported that uninsured patients had greater difficulty obtaining access to off-site specialty services, including referrals and diagnostic testing, than did patients with Medicaid, Medicare, or private insurance. Uninsured patients found to have more difficulty accessing specialty services than insured or those with Medicaid. As illustrated in Figure 2, those with Medicaid faced difficulties three times that of those with private insurance, compared to those without insurance, whose difficulties were more than 109 times more difficult than those with private insurance.*

Benjamin Sommers, Katherine Baicker, and Arnold Esptein. "Mortality and Access to Care among Adults after State Medicaid Expansions," *The New England Journal of Medicine,* September 13, 2012. 367:1025-34. Retrieved at www.nejm.org/doi/pdf/10.1056/NEJMsa1202099.

> "*Our study documents that large expansions of Medicaid eligibility in three states were associated with a significant decrease in mortality during a 5-year follow-up period, as compared with neighboring states without Medicaid expansions. Mortality reductions were greatest among adults between the ages of 35 and 64 years, minorities, and residents of poor counties. These findings may influence states' decisions with respect to Medicaid expansion under the ACA.*
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> *Our study shows a mortality reduction associated with state Medicaid expansions to cover adults. Using state-level differences in Medicaid expansion as a natural experiment avoids the confounding between insurance and individual characteristics (e.g., poverty or health status) that plagues cross-sectional observational studies. These results build on previous findings that Medicaid coverage reduces mortality among infants and children and are consistent with preliminary results of a randomized, controlled trial of Medicaid in Oregon, which showed significant improvement in self-reported health during the first year (although objective measures of health are not yet available and 1-year mortality effects were not significant and were imprecisely estimated)."*

J. Michael McWilliams et al. 2004. "Health Insurance Coverage and Mortality Among the Near-Elderly." *Health Affairs* (July 2004) http://content.healthaffairs.org/content/23/4/223.full.

> *"Our study demonstrated greatly increased mortality among the near-elderly uninsured relative to their privately insured peers. This finding was evident among white adults; those with low incomes; and those with diabetes, hypertension, or heart disease, which suggests that these groups are most likely to experience health benefits of expanding insurance coverage for uninsured people over age fifty. Our study also indicates that expanding health insurance coverage alone may not be sufficient to reduce the increased mortality experienced by near-elderly blacks. Reforms to expand coverage, such as a Medicare buy-in program or tax credits to purchase insurance, may produce sizable health benefits if they provide affordable coverage for the near-elderly uninsured, particularly those with low incomes or chronic illness."*

Katherine Baicker et al. "The Oregon Experiment – Effects of Medicaid on Clinical Outcomes." *The New England Journal of Medicine*, May 2, 2013. www.nejm.org/doi/full/10.1056/NEJMsa1212321.

> *This randomized, controlled study showed that Medicaid coverage generated no significant improvements in measured physical health outcomes in the first 2 years, but it did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.*

Joel S. Weissman, Christine Vogeli, and Douglas E. Levy. "The Quality of Hospital Care for Medicaid and Private Pay Patients." *Medical Care.* May 2013; 51:389-395. Retrieved at www.ncbi.nlm.nih.gov/pubmed/23358385.

> *Small national differences in quality between hospitalized Medicaid and private patients are promising, although merit close monitoring as states are forced to curb Medicaid reimbursements. Although quality for Medicaid patients varied by state, high correlations with private patients suggest that the factors driving quality have more to do with geographic factors in the delivery of hospital services than with state-established Medicaid policies.*

Austin Frakt, Ph.D., Aaron E. Carroll, M.D., Harold A. Pollack, Ph.D., and Uwe Reinhardt, Ph.D. "Our Flawed but Beneficial Medicaid Program," *New England Journal of Medicine,* April 21, 2011. Retrieved at http://bit.ly/hoLL5C.

> *"Medicaid has many problems, low reimbursement rates being arguably the most serious. If Medicaid's critics were seeking to raise its reimbursement rates and increase spending on the pro- gram, we would join their chorus. But they are using the invalid argument that Medicaid coverage is worse than no coverage at all to support proposals to cut back the program. Such an attack further damages this highly challenged program by undermining the political case for additional resources."*

Center for Budget and Policy Priorities, Fact Sheet on benefits of Medicaid Expansion on mothers and children at www.cbpp.org/files/Fact-Sheet-Impact-on-Women.pdf.

> *Expanding Medicaid would provide health coverage to low-income women irrespective of whether they are pregnant, resulting in better outcomes for both the women who gain coverage and the children they have in the future. Health coverage during the period before pregnancy allows women to receive preventive care like regular doctor visits, birth control, information about making healthy food choices, tobacco cessation programs, and substance abuse services that decreases their own health risks and makes it more likely that their babies will be born healthy if and when they become pregnant. For example, research shows that prenatal care for high-risk pregnant women reduces the incidence of costly premature births.*

E. Albert Reece, et al., "Intensive Interventional Maternity Care Reduces Infant Morbidity and Hospital Costs," *Journal of Maternal-Fetal and Neonatal Medicine,* 2002, Volume 11. Retrieved at www.ncbi.nlm.nih.gov/pubmed/12380679.

> *"The Temple Infant and Parent Support Services program demonstrated that infant morbidity could be reduced when a comprehensive prenatal program was made available to indigent patients, even if there were multiple factors that placed the mother and her infant at high risk for complications."*

Kelly Stamper Balistreri, PhD and Hsueh-Sheng Wu, MA. "Demographic Analysis of Low-Income Adults without Dependent Children: Implications for the Expansion of Medicaid." Center for Family and Demographic Research, Bowling Green State University, Ohio Family Health Survey 2010. Retrieved at http://bit.ly/15FRA6E.

> *"Our research hints that some of the future Medicaid enrollees may be childless adults that struggle with chronic conditions, possibly mental health and substance abuse problems, which make it unlikely that they could reach a level of employment to secure job-based insurance. This, in turn, may create a demand for mental health or substance abuse treatment services among the new Medicaid expansion population.*
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> *In an era when government policy is looking for strategies to broaden health insurance coverage and improve quality of health care while controlling costs, it is particularly important to understand the unmet needs and health patterns of Ohio's potential Medicaid expansion population."*