

**Could the Money Saved Through  
Uncompensated Hospital Care be  
Enough to Justify Medicaid  
Expansion in the State of  
Kentucky?**

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## **Could the Money Saved Through Uncompensated Hospital Care be Enough to Justify Medicaid Expansion in the State of Kentucky?**

### **Summary**

This paper examines the proposed Medicaid Expansion detailed under the Patient Protection and Affordable Care Act (ACA) and whether it would be fiscally responsible for the state of Kentucky to move forward with the expansion. While the federal government plans on covering a majority of the expense for the expansion, each state will be responsible for a portion of the costs incrementally increasing from 5% in 2017 to 10% in 2020 and beyond. Analysts and think tanks have examined the healthcare act's expansion and determined the individual states have a lot to gain financially for accepting the federal government's proposition. These experts have detailed the potential positive impact new money from the government would have on the states from increasing healthcare jobs to increasing tax revenue and driving consumer spending. Also, they have theorized the newly covered uninsured from the Medicaid expansion will reduce uncompensated care costs to hospitals significantly. Since states and localities finance approximately 30% of uncompensated care, they stand to save a substantial amount of money that essentially would pay for a majority of the state's share of the expansion.

Some states have previously implemented expanded state insurance programs, like the ones proposed in the ACA, permitting a platform of study by which to determine possible fiscal implications. This study examines the impact of some of these programs and how they reduced the number of uninsured individuals and their effect on uncompensated hospital costs in their particular state healthcare systems. Understanding the cause and effect of these programs is important in understanding the potential financial consequences for the state of Kentucky.

This study also provides a deeper analysis looking at the results of an expansion in Arizona. Arizona's particular Medicaid program change assimilates the one proposed by the Federal government for 2014 and thus provides a data viewpoint that may be helpful in analyzing a policy change for Kentucky. This analysis looks at uncompensated care before and after policy implementation. The results show the percentage of uninsured patient discharges from hospitals decreased slightly while overall Medicaid discharges increased inversely. Private insurance discharges decreased inversely to the number of Medicaid patient discharges. Furthermore, the hospitals in Arizona saw a significant increase in total Medicaid hospital charges with a slight increase in uninsured charges after policy implantation in 2001. Then, through the application of a sensitivity analysis, confounding variables were analyzed to assess causation and correlation. None of the results from the regression analysis displayed any statistically significant effect on uncompensated care. Overall, the results from the graphic analysis and the regression seem to be insignificant and inconclusive. Based on this analysis there is no certainty of saving significant amounts of state money on a reduction in uncompensated hospital care. More study is needed in order to determine if Kentucky should partake in the Medicaid Expansion.

## Problem Statement

The Patient Protection and Affordable Care Act (PPACA) is a healthcare measure intent on reforming the healthcare delivery system while increasing American's access to care through new policy provisions providing insurance coverage to the nation's uninsured. Insurance exchanges will be created to cover the uninsured who currently do not have coverage from either a commercial insurance provider, the state or the federal government. The other major initiative for providing insurance coverage to some of the nearly 48.6 million uninsured people in the United States is an expanded Medicaid program.<sup>1</sup> The original provision in the Affordable Care Act (ACA) called for each state to set up an exchange and to prepare a Medicaid expansion plan to cover state residents up to 138% of the Federal Poverty Level.\* Then, in the summer of 2012, the Supreme Court ruled the federal government could not force the states to change their Medicaid programs. Whether to expand Medicaid would be a decision left to each individual state. While the federal government plans to cover 100% of the program starting in 2014 for the first three years, the ensuing costs will be covered at 5% by the states in 2017, 6% in 2018, 7% in 2019 and 10% in 2020 and beyond. Already strained state budgets will be asked to stress further during uncertain financial times.

From the viewpoint of the federal government the Medicaid expansion will help to cover more of the nation's 48.6 million uninsured. Also, the federal government will pay a very high share of the new Medicaid costs. The proponents for the measure argue that increased insurance coverage to more individuals would mean reducing charity losses from hospitals, reducing payments to support uncompensated care, and would be economically beneficial to

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\* Originally, the ACA called for an expansion to cover to 133% of the Federal Poverty Level, but the new modified adjusted Gross Income (MAGI) tax rule gives a 5% income disregard, bumping the effective level up to 138% of FPL.

society because more people would have better access to care promoting healthier more productive lives. Furthermore, the new money from the federal government, an anticipated \$11.9 billion nationally, could be a financial windfall that could help the states' struggling economies.

Potentially, the state of Kentucky could save money by going along with the Medicaid expansion.

Since the Federal government will cover nearly 90% of the costs over the first six years of the program, Kentucky will spend between \$515 - \$695 million to cover these adults during the expansion or approximately 3.5% to 4.7% more than what Kentucky would have spent on Medicaid during the first six years without the expansion.<sup>2</sup> In Kentucky there are 346,400 uninsured adults who would be eligible for Medicaid if the state expanded its Medicaid program.<sup>3</sup> Unfortunately, Kentucky is one of the states struggling with budget deficits forcing realignment of spending priorities which could hurt the introduction of any new spending program, no matter the potential costs. The state of Kentucky has been facing budget shortfalls over the last couple of years in Medicaid and most recently has had to borrow up \$100 million dollars from future budgets to fill funding gaps.<sup>4</sup>

Decision makers in several states, along with legislatures in the state of Kentucky, are voicing concern over what they perceive to be problems in the new Medicaid Expansion. First of all, the entire Patient Protection and Affordable Care Act is a politically hot and highly contested law that has proven divisive in Washington and the entire country. This public contention was exhibited in the 2010 midterm elections by a swaying of the electorate to vote for more conservative representatives with platforms opposing government run healthcare. Although the national government is covering a large majority of the expense of the new Medicaid enlargement, some of the costs will be parlayed to the already financially strapped states, including 50% of the administrative costs associated with managing new enrollees.<sup>5</sup> Additionally, there is rising fear that a "woodwork type effect" might occur where those individuals that have eligibility for

Medicaid and are not presently enrolled would become more engaged and likely to register because of the publicity concerning the new program. The currently eligible, un-enrolled will cost states even more money, because the traditional federal match, (FMAP between 50-75%) would apply instead of the more generous expansion payment. Finally, there is deep concern that the fiscally strained federal government may not be able to uphold its end of the bargain and provide such a generous matching rate several budget years down the road.

Some states have already expanded their Medicaid or state insurance programs to cover more citizens. Several other states have decided to expand Medicaid coverage starting in 2014 to meet the federal government's request to cover more citizens. The overall idea of this Capstone study is to look at the validity of the cost savings to the state of Kentucky if it expands Medicaid to cover more uninsured Kentuckians. Analysts have determined through various modeling techniques that states will save at least half of the money spent on the Medicaid expansion through reductions in the amount of their uninsured population. More specifically, it has been theorized states would save a significant amount of "out of pocket" expense by the reductions in uncompensated care that would result at the state's hospitals.<sup>6</sup> Several states have already enacted legislation allowing for Medicaid expansions, providing the necessary information for a tangible analysis of the potential for reductions in uncompensated care by providing health insurance to the uninsured.

Meanwhile, the state of Kentucky remains undecided about expansion. Governor Steve Beshear will be deciding sometime in the spring of 2013. A survey of 812 Kentuckian's conducted by the American Cancer Society in January 2013 concluded 63% of respondents said they would support accepting federal funding to expand Medicaid.<sup>7</sup> In fact, Governor Steve Beshear (D), when asked about the expansion in July said, "If there is a way that we can afford it

that will get more coverage for more Kentuckians, I'm for it." However, state lawmakers are putting pressure on Beshear to reject the expansion. (Office of Gov. Beshear press release 6/28)

## Background

In the year 2013 the state of Kentucky has a unique opportunity to expand its Medicaid enrollment to include non dependent adults whose income is up to 138% of the Federal Poverty Level. Established in 1965 under the Federal Social Security Act, Medicaid was developed as a state run government health and long-term care insurance program receiving subsidy from the federal government for services rendered to a low-income population. The population covered now numbers approximately 60 million individuals including children (29 million), pregnant women, parents, seniors and individuals with disabilities.<sup>8</sup> Each state has discretion in terms of eligibility and benefits that must fall within federal minimum standards.

Total Medicaid spending by the federal and state governments in 2011 was \$407.7 billion.<sup>9</sup> According to models run by the Urban Institute, the Medicaid expansion and certain other elements of the Affordable Care Act could potentially lead state Medicaid spending to increase by \$76 billion over a 10 year period from 2013-2022 which will be an approximate 3% increase over the projected state Medicaid spending for the same time period.<sup>10</sup> Meanwhile, federal spending on the program is predicted using the same models over the same 10 year time period to increase by \$952 billion (a 26% increase).<sup>11</sup>

The total population of Kentucky is 4.29 million and the state has an unemployment rate of 8.0% (US 7.8%).<sup>12</sup> The uninsured population in Kentucky is 627,200, representing approximately 15% of the total population (US 16%).<sup>13</sup> Twenty one percent of the Kentucky population is covered by Medicaid at some point during a fiscal year.<sup>14</sup> Additionally, 32% of the total population of Kentucky falls under 138% of the federal poverty level (US 28%).<sup>15</sup> The population

most likely affected by the Medicaid expansion rule change would be the population of uninsured adults with non-dependent children under the 138% FPL reference line. For the first time, this group would be eligible for Medicaid in Kentucky. Under the current national Medicaid eligibility requirements, parents comprise 45%, people with disabilities comprise 35%, and childless adults make up the remaining 20% of Medicaid adults. In contrast, with the new Medicaid eligibility rules, parents comprise approximately 35%, disabled adults comprise 10-15%, and childless adults make up the remaining 50-55% newly eligible.<sup>16</sup> In the state of Kentucky the number of uninsured with non-dependent children in 2010-2011 was 390,900 (22% of total pop), whereas the total number of non-elderly below the 138% poverty line in Kentucky was approx. 346,400 total people. Demographically, 53% of the uninsured are male and 47% are female, 74% white, 11% Black, and 11% Hispanic (of the total 623,500 uninsured people in state).<sup>17</sup> The Congressional Budget Office (CBO) estimates a take up rate among newly eligible uninsured adults to be approximately 66-70%, meaning Kentucky is looking at potentially between 228,624 and 242,480 new Medicaid enrollees after 2014.<sup>18</sup>

## **Literature Review**

### Participation:

Many consider how being uninsured affects people's access to needed medical care. A study performed in 2012 by a Kaiser sponsored commission on Medicaid and the uninsured, discovered access barriers can sometimes mean the uninsured are less likely to receive preventative care, more likely to be hospitalized for preventable conditions, and more likely to die in the hospital because they are more likely diagnosed in later stages of progressive diseases.<sup>19</sup> Furthermore, more than a third of that non-elderly adult population has a chronic condition.<sup>20</sup> People without health insurance are more likely to forego medical care because of problems with access and costs. More

than 25% of adults lacking coverage say they have skipped care in the past year because of costs. Thirty percent of the uninsured compared to 12% of Medicaid recipients postponed care, while 24% indicated they could not afford prescription drugs compared to 14% for Medicaid.<sup>21</sup> The uninsured are less likely to follow physician after care plans and when they are hospitalized they receive fewer diagnostic and therapeutic services and have higher mortality rates than the insured.<sup>22</sup>

By average estimates, the Affordable Care Act will result in 16 million new subscribers to Medicaid.<sup>23</sup> An important aspect in determining the economic impact of the new healthcare provision is the type and amounts of patients that will elect to participate in the new Medicaid expansion. At this time many groups have looked at this problem and estimated enrollments to varying degrees. Although, there is a personal responsibility requirement in the President's plan, there is no specific law or mandate requiring every eligible American to participate, therefore estimates based on assumptions are the best that can be done at this point.

Surveys in 2009 from the expansion in Massachusetts, provide basis for a national estimate of the Medicaid take-up in the range of 52-81% for childless adults with incomes below 138% of the FPL.<sup>24</sup> Other public programs, like unemployment benefits, Supplemental Nutritional Assistance Programs (SNAP), and the Earned Income Tax Credit Program could also serve as a reference for understanding enrollment potential. These programs have traditionally seen enrollments uptakes from 54-86%.<sup>25</sup> When it comes to enrollment for the Medicaid Expansion in the Affordable Care Act, some estimate the participation numbers will initially be low, because historically the childless adults without disabilities tend to have lower overall participation rates.<sup>26</sup> Furthermore, political advertising in some states has created a feeling of discontent among the citizens for anything relevant to the Affordable Care Act and may affect participation rates.<sup>27</sup> Contrarily, others are estimating higher than normal take-up rates because of the new streamlined



process calling for a single portal of entry for Medicaid, a new uniform financial eligibility standard based only on income, simpler rules for determining eligibility, and the personal responsibility requirement. These groups estimate the take-up to be approximately 57-82% during the initial registration period.<sup>28</sup> And, finally, the Office of the Actuary at the Center for Medicare and Medicaid Services (CMS) assumed a participation rate of 95% and an estimated 26 million newly enrolled into the program by 2020.<sup>29</sup>

A key question in determining the cost of this newly expanded population is what the new group will look like based on potential health status and healthcare. Will the new group have serious physical and mental health problems and a large number of chronic conditions and thus be relatively expensive? Studies have analyzed the costly health issues related to lack of health insurance. Uninsured patients are more likely to be diagnosed in expensive advanced stages of cancer. Based on estimates from the Urban Institute, 22,000 people between the ages of 25 and 64 died in 2006 prematurely due to lack of health insurance. People who were uninsured at anytime during 2007 were nearly twice as likely as those insured to have unpaid medical bills or related bad medical debt (61% vs. 33%).<sup>30</sup>

Other data suggests the potential new group to be added during the Medicaid expansion will be healthier than those already covered by Medicaid, but are likely to be more expensive than those who remain uninsured and will be likely to have two or more chronic conditions and more likely to be limited in their ability to work.<sup>31</sup> The total expense and overall health of the new group is largely contingent on the level of participation rates in the new program under the reform. The sickest patients are the most likely to enroll, creating an adverse selection issue. Thus, if the program has low participation rates, the risk of adverse selection will be high, making it very likely the new population will be relatively expensive. The projected costs of the sicker group enrolling will be 1.3 times higher than those uninsured who do not enroll.<sup>32</sup>

A study of health coverage in Oregon found newly insured Medicaid enrollees were more likely to receive care from a hospital or doctor than the uninsured. Of those studied, 35% increased the likelihood of having an outpatient visit and 15% increased the potential of taking a prescription, and they reported improvement in mental and health status.<sup>33</sup> Also, a study published in the *New England Journal of Medicine* found expansions in Medicaid eligibility for adults were associated with reduced mortality and improvement in access to care and self-reported health status.<sup>34</sup> However, a study that examined an early Medicaid expansion in California and the potential for better health outcomes for early prenatal care found no significant or conclusive evidence that the expanded provision of care had any better results or health outcomes for needy patients.<sup>35</sup> Of course further review needs to be considered, and this obviously is not the patient population that will make up the currently proposed Medicaid Expansion under the ACA.

On the other hand, if participation rates are extremely high, the new enrollees are likely to have health characteristics similar to the low-income uninsured or privately insured childless adults. Overall, the new group contingent on high participation rates on average will likely be healthier and less costly to cover than those currently enrolled in Medicaid. The demographics of the U.S. population under 138% of the FPL are as follows: 50% are uninsured at a point in time, 8% are covered under Medicaid as nondisabled adults, 12% are enrolled in Medicaid through SSI or are dual eligibles (Medicaid+Medicare), 5% enrolled in Medicare because of disabilities, and 26% have private coverage. Parents currently covered on Medicaid account for 29% of the total population under 138%; 5% are dual eligibles or on Medicare because of disabilities, 22% have private coverage and 44% are uninsured. The uninsured childless adults are most likely to be between the ages of 19 and 34. Currently, 60% of childless adults are male, while 60% of the remaining 40% are females already on Medicaid. The health status of those new enrollee childless adults seems be relatively good in that only 18% of the uninsured are in fair or poor health and

only 13% have fair or poor mental health (12% of those with private insurance are in fair or poor health and 8% with fair or poor mental health). Also, 18% of the uninsured report two or more chronic conditions while 28% of those with private insurance report two or more chronic conditions. Furthermore, 15% of uninsured and 13% of privately covered adults report work-related limitations. Also, the uninsured childless adults in this group report being more likely than currently enrolled Medicaid users, to take risks, to believe they do not need health insurance, it is not worth the cost, and that they can overcome illness without medical help.<sup>36</sup>

### Woodwork Effect

In discussing participation rates for the new Medicaid expansion under the Affordable Care Act it is important to consider how the status quo may change if a state like Kentucky decides not to partake in the new policy. Even if no states participated in the Medicaid expansion, the total national Medicaid enrollment would still be likely to increase by 5.7 million people. Keeping the status quo in this case will still result in a reduction of the number of uninsured nationally by 28%. (Holahan 2012). Provisions in the healthcare reform bill that will make the enrollment process for Medicaid easier and more coordinated along with the increased publicity about the program is very likely to increase patient participation.<sup>37</sup> This “noise effect” is called the Woodwork effect”, because when people hear about something being offered they come out of the woodwork to see what is happening. Essentially, people who did not realize they were previously eligible for Medicaid, will, in response to the publicity (“noise”), be made aware and therefore sign up for the benefit they were already pre qualified to receive. Simulation models based on previous research at the Urban Institute have estimated average adoption rates during the new Affordable Care Act enrollment will be approximately 23.4% among currently eligible but not enrolled individuals (Holahan 2012). Furthermore, the Urban Institute studies also found that if the states do not

implement the new proposed expansion they will still see the increased participation due to the new ACA provisions nonetheless and it will cost the states an additional \$68 billion and the federal government \$152 billion above the levels without the ACA. The states will pay a relatively high share because the newly awakened “woodwork effect” enrollees will be those who qualify for the pre-ACA federal matching rates (Holahan 2012). States will have to pay the approximately 20-40% remaining from the Federal Medical Assistance Percentage (FMAP) made by the federal government to the program. Hence, the states will be paying for these Medicaid participants under the old criteria instead of paying only 10% under the new plan.<sup>38</sup>

The current number of Kentuckians enrolled in Medicaid is 758, 000 and via the increased attention to Medicaid an additional 43,000 people could be added even if the state does not expand its program. Alternatively, Kentucky could expand Medicaid potentially adding a total of 240,000 new enrollees, denoting a 197,000 incremental increase over not expanding Medicaid.<sup>39</sup>

### Economic Stimulus

Hospitals could potentially see an increase in revenue via a new patient population under expanded Medicaid that would now utilize hospital and outpatient services. Potentially providers of care would now be reimbursed for care provision that was in the past uncompensated. In fact, it is estimated that if all states participated in the program hospitals nationwide could collectively receive \$314 billion worth of new revenues. (Holahan 2012)

With increased Medicaid funding to a state, there is a potential for a multiplier effect. In order for the multiplier effect to work in generating business activity, jobs, wages and related monies must be received from outside the state. Use of health services via Medicaid brings new money into the state in the form of federal matching dollars (FMAP) from the federal governments’ entitlement program that pays a percentage of the overall costs of the state run program. Medicaid

spending potentially adds to the state economy in both direct and indirect ways. Payments to hospitals, physicians and nursing homes directly impact the economy by paying for goods, services and salaries. Subsequently, a ripple effect occurs where these dollars find their way secondarily into the economy via new purchases and additional earnings.<sup>40</sup> It is estimated by the RIMS II economic model that a 5% increase in Medicaid spending could provide a \$416 million increase in business activity and up to a 3,670 potential increase in jobs in the state of Kentucky.<sup>#41</sup>

### Charity Care

The impact and associated costs of the widespread lack of health insurance coverage in the United States are growing, far reaching, and can be measured. A safety net of hospitals, community health centers and health departments provides care to people without health insurance. When someone uses hospital services for which they fail to pay, this level of uncompensated care is referred to as charity care (care provided with no expectation of payment), community care, indigent care or bad debt (payment is expected but never received). The cost of uncompensated care continues to rise. A third of the medical costs for the uninsured are uncompensated.<sup>42</sup> Uncompensated care cost approximately \$57 billion in the United States in 2008.<sup>43</sup> Approximately, seventy percent (\$40 billion) was paid for by the federal government, while the remaining 30% is paid by state and local monies appropriated for the uninsured. Federal and local funds are paid to hospitals for this care via Disproportionate Share Hospital (DSH) funding. The Medicaid DSH program requires hospitals to provide charity care to certain qualifying individuals. These state funds follow the Medicaid Federal Matching Rate (FMAP) and are provided to offset the costs of treating the uninsured. Lost hospital

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<sup>#</sup> The RIMS II model is created by the Department of Commerce, Bureau of Economic Analysis (2007). The data shows the relationships among 500 industries in the economy. The model adjusts and updates these relationships to reflect a state economy's current industrial structure, trading patterns, wage and salary data, and personal income data.

payments accounted for 60% of the total costs of uncompensated care.<sup>44</sup> In the year 2011, Kentucky received \$145 million in payments from the federal government in the form of DSH payments (Kaiser State Health Facts).

If all states adopted the Medicaid expansion, total uncompensated care could decline by approximately \$183 billion (2012-2022) compared to the implementation of the ACA without any expansion. Typically, local and state government support about 30% of the uncompensated care and if a conservative estimate is used like the one estimated and used by the Urban Institute in October 2012, states could assume a 33% share in the savings resulting in a decline in funding of charity care by \$18 billion.<sup>45</sup> According to the Holahan (2012) study, combining the newly proposed Medicaid costs of \$8 billion with an estimated \$18 billion saved on uncompensated care, the Medicaid expansion could save a total of \$10 billion over the time period from 2013-2022, compared to the ACA without the expansion.(Holahan 2012)

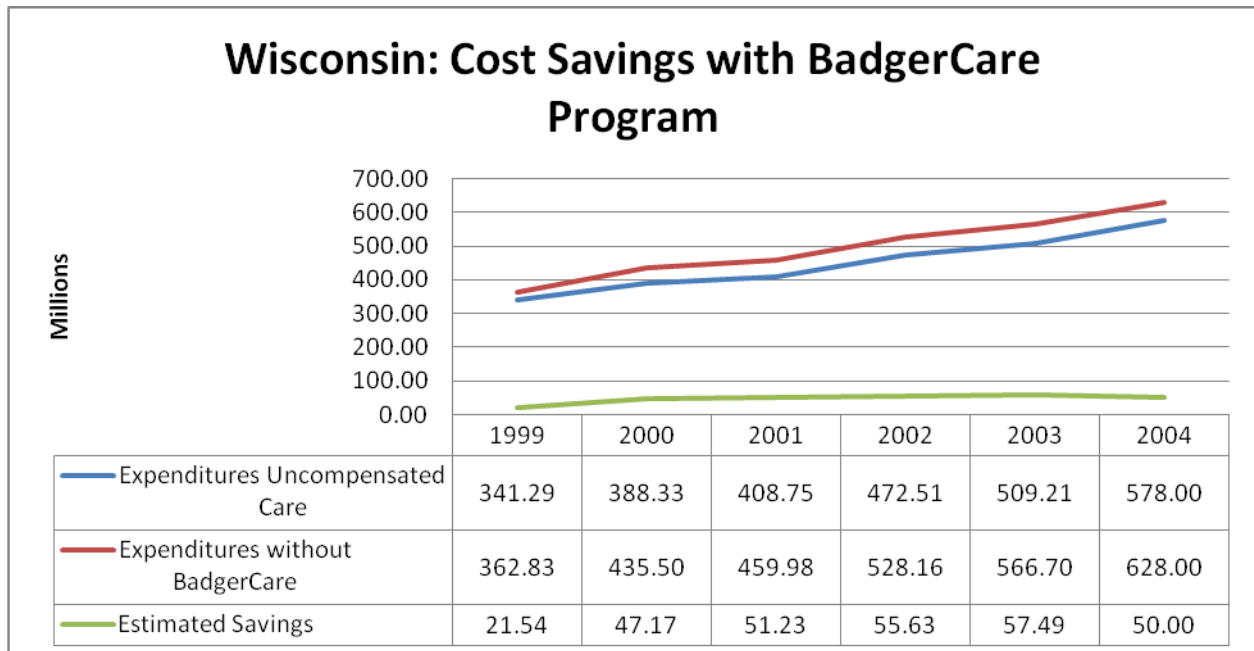
The anticipated incremental cost to the state of Kentucky for the total Medicaid is essentially \$1.2 billion (2013-2022). The estimated amount of uncompensated care in the state of Kentucky that could potentially be saved is \$451 million (2013-2022). Therefore, the net cost to the state of Kentucky is projected to be \$845 million which is a 3.2% increase for Medicaid expansion over the baseline in 2012. (Urban Institute Analysis, HIPSM 2012)

Several studies have looked at the effect of reducing the number of uninsured on uncompensated care. One study looked specifically at providing more care to uninsured instead of adding money to uncompensated care pools or various other hospital funding programs. The study was conducted in New Jersey after a period in the early 80's of out-of-control uncompensated hospital expenses. During the study time period it was determined that uninsured expenses at the hospitals went down, because it was believed the dissemination of uncompensated care dollars (DSH funds) improved the access and quality of patients experience reducing ensuing emergency

care provision.<sup>46</sup> Also, several studies have looked at the policy change to the Medicaid program that increased insurance coverage through the State Children's Health Insurance Program (SCHIP). Using national cost data from 1987-1990, Dubay, Norton, and Moon found the Medicaid expansions for pregnant women and children decreased uncompensated care by 5%.<sup>47</sup> Contrarily, using a national database from the American Hospital Association, Davidoff and colleagues found a negative relationship between increases of Medicaid eligibility and hospital income, although there was a positive relationship between increased payments under Medicaid and financial health of hospitals.<sup>48</sup> Oregon instituted a health insurance experiment in 2008, and embarked on a study to determine whether providing insurance to an uninsured population similar to the one proposed in the ACA expansion would facilitate higher use of healthcare services with positive healthier outcomes. A group of people meeting the anticipated new Medicaid criteria were selected by a lottery and given a chance to apply for Medicaid. In the following year after the study, the treatment group was 25% more likely to have insurance than the control group (those not selected). Also, the treatment group had statistically significant higher health care utilization (including primary and preventative services), lower out of pocket expenditures and debt, and better overall health than the control (Survey).<sup>49</sup> Another study that has provided valuable insight on these questions is one provided on MinnesotaCare changes by Blewett and Davidson (2003).<sup>50</sup> MinnesotaCare was health reform legislation passed in 1992 as a state subsidized health insurance program for the working poor. This program was an expansion of their current program and included single adults or couples without children up to 125% FPL. The study found a significant inverse relationship between enrollment in a state-subsidized insurance program and levels of hospital provision of uncompensated care. A one percentage increase in MinnesotaCare enrollment resulted in a \$2.19 decrease in uncompensated care expenditure per capita. The overall cumulative savings through the MinnesotaCare program was \$58.6 million over 5 years.<sup>51</sup> A

Wisconsin study looked at the BadgerCare program which provides health insurance to low-income working families with children up to 185% of the FPL. During the 1999-2004 period of the analysis, a cost savings of \$283 million was realized by a reduction in spending for uncompensated care. (Table 1).<sup>52</sup>

**Table 1.**



Hospital Uncompensated Care Savings from BadgerCare, 1999-2004(Millions of Dollars)  
Impact of Badger Care on Hospital Uncompensated Care, APS Healthcare 2006

**Other states already with Medicaid Expansion**

According to data supplied by the Kaiser Foundation on the State Health Facts website there has already been a 27.4% increase in U.S. Medicaid enrollment by individuals made eligible under state guidelines adding individuals to 100% of FPL. Over the last fifteen years, thirteen states have implemented some form of a Medicaid expansion. Typically, these changes to state Medicaid eligibility occur through section 1115 waivers.\* The states involved in making eligibility changes were Vermont (1996), Minnesota (2011), Arizona (2001), New York (2001), Maine (2002), and California, Colorado, Idaho, Illinois, Michigan, New Jersey, New Mexico,

\* Section 1115 Waivers: States can apply for Medicaid program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP



Oregon (2002) and Wisconsin. Arizona and Illinois by virtue of program eligibility and number of those enrolled most closely reflect the changes proposed under the Affordable Care Act. These two programs all expanded coverage to childless adults to at least 100% of FPL. Furthermore, they involve increases to their Medicaid populations that were much more significant than the programs implemented by the other states. (Table 2)

Table 2.

States	Policy Date	Eligibility	Premiums/ Cost Sharing	Enrolled	Most Resemble Kentucky Expansion
Proposed Expansion Kentucky	2014	Childless adults up to 138% FPL	No	240,000	
Arizona	2001	Childless adults up to 100% FPL; parents at 100-200% FPL	No	212,941	X
California	2002	Parents not eligible for Medicaid up to 200% FPL		275,000	
Colorado	2002	Pregnant women not eligible for Medicaid at 133-185%FPL	No	13,000	
Idaho	2004	Children up to 185% FPL	No	1,400	
Illinois	2002	Parents 39-185% FPL; Children 133-200% FPL. Individuals up to 185% FPL in previous state programs	No	300,000	X
Indiana	2001	Parents not eligible for Medicaid up to 200% FPL	Yes	18,694	
Maine	2002	Childless adults up to 125% FPL;	No	15,087	
Michigan	2004	Childless adults to 35% FPL	No	62,000	
New Jersey	2003	Parents up to 200% FPL	yes	12,000	
New York	2001	Childless adults 78% FPL	Yes	683,918	
New Mexico	2002	Nonelderly adults not eligible Medicaid, Medicare, or CHAMPUS up to 200% FPL	No	40,000	
Oregon	2002	Children and Pregnant women 170-185% FPL; parents and childless adults 100-185% FPL	Yes	43,554	
Vermont	2001	Childless Adults to 150% FPL	Yes	35,700	
Wisconsin	2001	Childless Adults to 200% FPL	Yes	56,300	

Data from Kaiser Commission on Medicaid and Uninsured and Coughlin 2006<sup>33</sup>

## **Study Approach:**

The basis for the assumption of saving money on uncompensated care to alleviate the costs of the new Medicaid expansion is the association between increasing access to care for the uninsured and the resulting reduction in uncompensated care to the hospitals. This reduction is expected to reduce the state's portion of payment for charity care. Therefore, in order to better understand the financial implications of the proposed Medicaid expansion policy, I sought to answer the question of whether increased medical insurance to uncovered individuals would generate a reduction in uncompensated emergency room visits and would therefore be economically beneficial to the states. In order to complete this type of study it was necessary to look at data from individual states that had already implemented a Medicaid policy like the one proposed under the Affordable Care Act. Also, it was important to find an implementation that most resembled the one proposed for the state of Kentucky and various other states across the country. First, I analyzed studies and data on states where they had already experienced a change in Medicaid enrollment. In 2001 Arizona increased the income eligibility requirements for receiving Medicaid by gaining a 1115 waiver from the government for the experimental program. The Arizona program required no premiums and no cost sharing and covered childless adults up to 100% of the FPL and parents from 100-200% of the FPL. Also, the program in Arizona was able to enroll approximately 212,200 new enrollees.

For this Capstone, I elected to look at aggregate state hospital discharge data to try and discern the levels of change in uncompensated care following the policy implementation to determine if the change had a causative effect. I specifically choose the data because it was the only consistent data over the specified time period I was able to obtain. The discharge information is from the same bank of reporting hospitals and it had several years before the policy and several years after to allow for the potential to see change. The other data resources I worked with lacked consistency in reporting

structure (different hospitals, different criteria) and they also had too much missing information to analyze change over time.

Then I conducted an analysis based on data I acquired from the Healthcare Cost and Utilization Project (HCUP) from the U.S. Department of Health and Human Services, for the state of Arizona. I examined the Arizona data from 1997 to 2005, because it was the data provided in the HCUP and it gave me adequate time to sample before the policy was implemented and several years following the 2001 policy change. In my analysis I was trying to understand the financial burden the uninsured may have caused on emergency room outpatient services before the policy implementation and whether there was a significant difference in uncompensated care after the policy change. Then I looked at a state with similar characteristics in population, unemployment, and hospital discharge information, Washington, to see if there were any observable issues that could have an effect on uncompensated care other than the policy change. (Table 3)

*Table 3*

<b>Year 1997-2000</b>	<b>Total Population (4yr Avg)</b>	<b>Unemployment (4yr Avg)</b>	<b>Total Discharges (4yr Avg)</b>	<b>% Medicaid Discharges (4yr Avg)</b>	<b>% Private Insurance Discharges (4yr Avg)</b>	<b>Mean \$ Uncompensated Discharge (4yr Avg)</b>
<b>Washington</b>	5.79 Million	4.93%	537,865	17.69%	41.12%	\$8,541
<b>Arizona</b>	4.95 Million	4.33%	542,638	15.59%	45.58%	\$9,318

Data from HCUP

To try and understand the potential effect for this type of policy change, I looked at aggregate uncompensated discharge data in a time series analysis form other states that underwent a Medicaid expansion to determine any significant changes in uncompensated care. I examined Colorado's outpatient emergency room information in regard to a Medicaid expansion change they

implemented in both 2004 and 2009. This data is more recent and more likely to represent the environmental circumstances Kentucky faces in the near future for its Medicaid expansion, because economic forces that may be influential on Medicaid uptake, unemployment and rate of uninsurance are likely to be relatable due to the closeness in time period. Furthermore, I looked at uncompensated discharge data from Maine, New York, Oregon and Minnesota to corroborate potential changes in uncompensated care related to a Medicaid expansion policy change.

(Appendix 1)

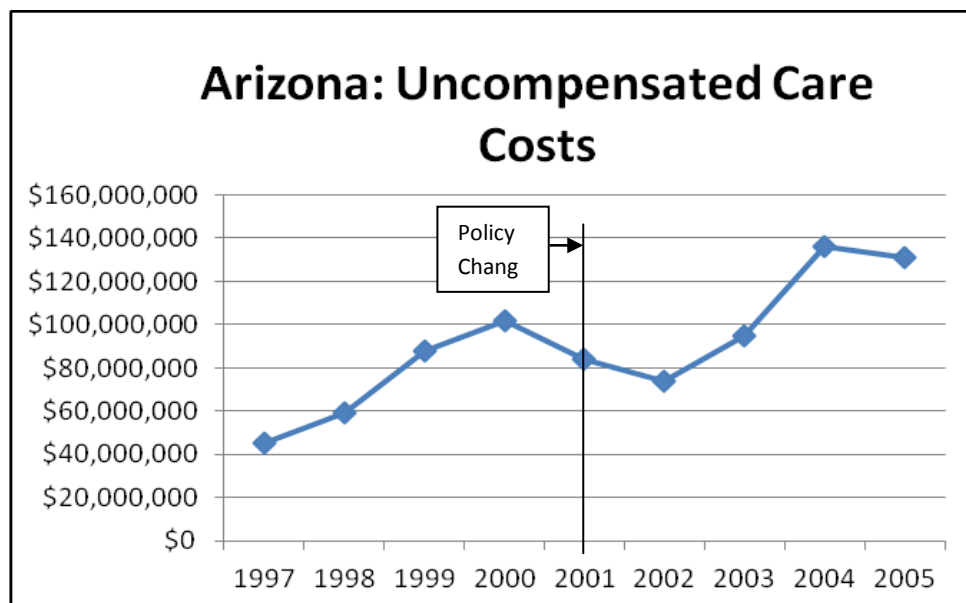
Then I conducted a linear regression to determine if any outside variables had a causative effect on the proportion of uncompensated care. My dependent variable was the uncompensated discharges from 1997 through 2005. These data and the ensuing independent variables were collected from the Agency for Healthcare Research and Quality project: HCUP (Healthcare Cost Utilization Project). All discharge costs were adjusted to 2005 dollars by using the Consumer Price Index (CPI). Previous research has recognized several variables that could influence rates of uncompensated care.<sup>54</sup> The control variables I identified and assessed were Total Population, Total Population on Medicaid, Unemployment, Private Insurance Discharges, Age 18-44 Discharges and Undocumented Immigration Population. Total Population acts somewhat as a control to understand if there is bias problem with the measurement, meaning if the population rises in direct proportion with the increase in uncompensated care then the policy may have had no effect. As the number of uninsured goes down in relation to the policy change then the Total Population on Medicaid should go up. Unemployment data from the Bureau of Labor Statistics should show a correlation to increases in Medicaid and uninsured discharges when the unemployment goes up. When looking at the number of Private Insurance Discharges, it is important to consider “crowd out” that may happen in regard to increased Medicaid coverage for this population. Also, the age group most likely affected by the new policy is the uninsured 18-44

yr. old childless adult, so therefore it is important to consider the relationship between this age group and its affect on uncompensated care discharges. Finally, Arizona is a border state so it is essential to consider the consequence a large increase in immigration might have on uncompensated care.

**Results**

This study uses annual hospital data from several of the states that have previously implemented Medicaid expansions and specifically a deeper analysis looks at the results of an expansion in Arizona. Arizona’s program change reflects the one proposed by the Federal government for 2014 and thus provides a data viewpoint that may pose helpful in analyzing a policy change for Kentucky. A chart analysis looks at uncompensated care charges before and after policy implementation. The data is adjusted to the Consumer Price Index for 2005 and the uncompensated care shown in the graph is 30% of the total uncompensated care costs reflecting the state of Arizona’s share in paying for uncompensated costs. The results show that uncompensated care costs dropped slightly following the policy change, but then increased to levels higher than those seen previously. (Table 4)

Table 4



Data from HCUP hospital discharges, CPI index, \*Assistant Secretary for Planning and Evaluation ASPE. US Dept of Health and Human Services.

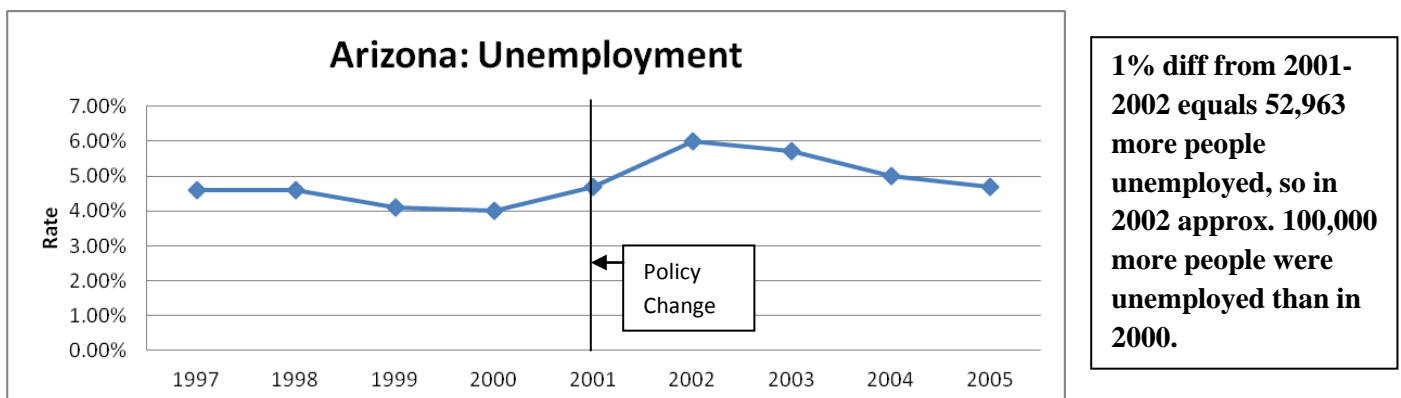
I ran a one tailed, paired unequal sample t-Test to assess the effect of the policy change on uncompensated hospital discharge costs. The Null hypothesis for the analysis was that the policy change had no effect on discharge costs before and after the policy change. The t-Test showed a probability of 0.0685 that our Null hypothesis is true. Therefore, I can't reject the Null hypothesis because the value is more than the pValue of .05 showing only a slight change that occurred because of the policy implementation. (Table 5) This information relays the potential problem of only having 9 total observations causing a high probability of a Type II error of not rejecting the Null hypothesis when in fact it should be rejected.

Table 5  
t-Test: One tailed, paired unequal variances

	Period 1 1997-2000	Period 2 2001-2005
Mean	\$73,580,184	\$104,011,479
Variance	6.6414E+14	8.00898E+14
Observations	4	5
P(T<=t) one-tail	0.0685	

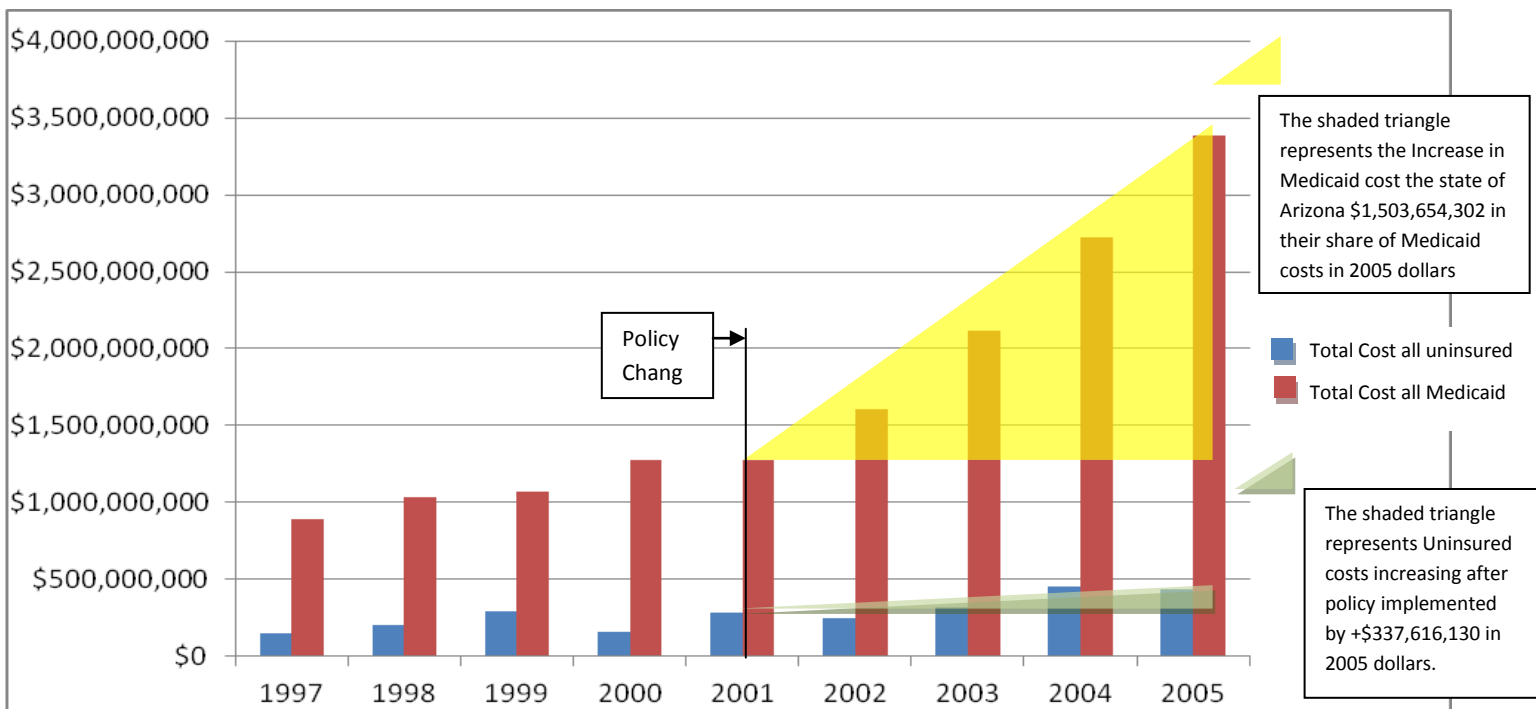
Other important factors to consider that may have impacted the results are the economic downturns caused by 9/11, the dot.com and the stock market crash of 2002. All of these events happened during the second time period from 2001-2005 and could have had an impact on the number of people becoming uninsured or underinsured. As can be seen in the following table unemployment did increase during the second period in the study. (Table 6)

Table 6



The purpose of this study was to see if a policy recommending the expansion of Medicaid to cover more of the uninsured population would have a positive effect on reducing uncompensated hospital care and consequently be cost effective. In this example (Table 7) hospital discharges increased for the uninsured population costing an additional \$337,616,130 in 2005 dollars. If you take 30% of that number representing the state of Arizona’s share of covering uncompensated care with Disproportionate Hospital Share (DSH) payments, Arizona will owe the hospitals an additional \$101, 284, 839 over a four year period. Additionally, the state’s portion of Medicaid will cost an additional \$1,503,654,302 over the same four year period, because of the newly insured. (Table 7)

Table 7

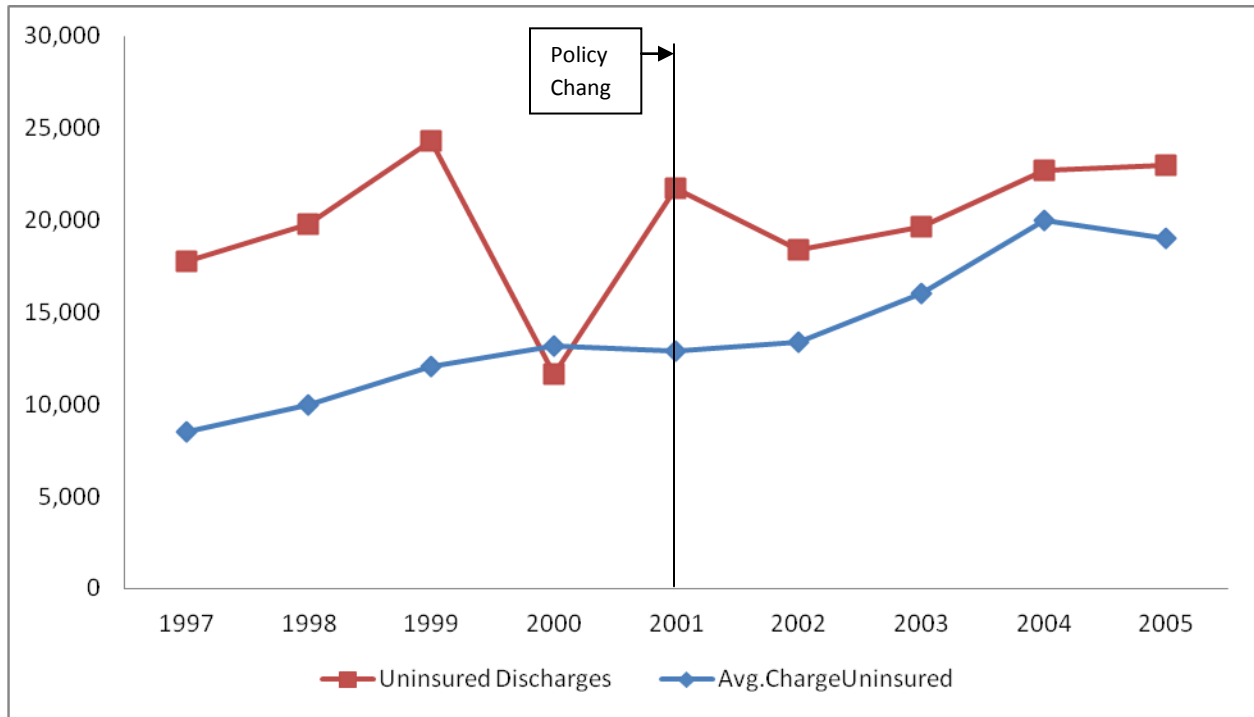


Data from HCUP hospital discharges, CPI index, \*Assistant Secretary for Planning and Evaluation ASPE. US Dept of Health and Human Services.

This increase is probably due to increasing of uninsured Arizonians due to economic issues going on during this period. The number of uninsured discharges increased over the time frame from 2001-2005 along with the average charge per uninsured discharge. (Table 8)



Table 8



Data from HCUP hospital discharges.

	Uninsured charge in 2005 dollars	Uninsured Discharges
1997	\$8,535.19	17,774
1998	\$9,989.23	19,782
1999	\$12,025.79	24,281
2000	\$13,184.81	25,769
2001	\$12,869.76	21,712
2002	\$13,371.34	18,411
2003	\$16,026.539	19,676
2004	\$20,021.72	22,717
2005	\$19,020	23,015

Then through the application of a linear regression analysis I tried to determine if certain variables had an effect on the dependent variable uncompensated care discharges. Based on my literature review I was able to ascertain certain dependent variables that could be analyzed to assess causation and correlation. The independent variables I identified and assessed were Total Population, Total Population on Medicaid, Unemployment, Private Insurance Discharges, Age 18-44 Discharges and Undocumented Immigration Population. None of the results displayed any statistically significant relationship with resulting changes in uncompensated discharges due to the fact I did not have enough observations (n=9) to make a proper analysis. (Table 9)

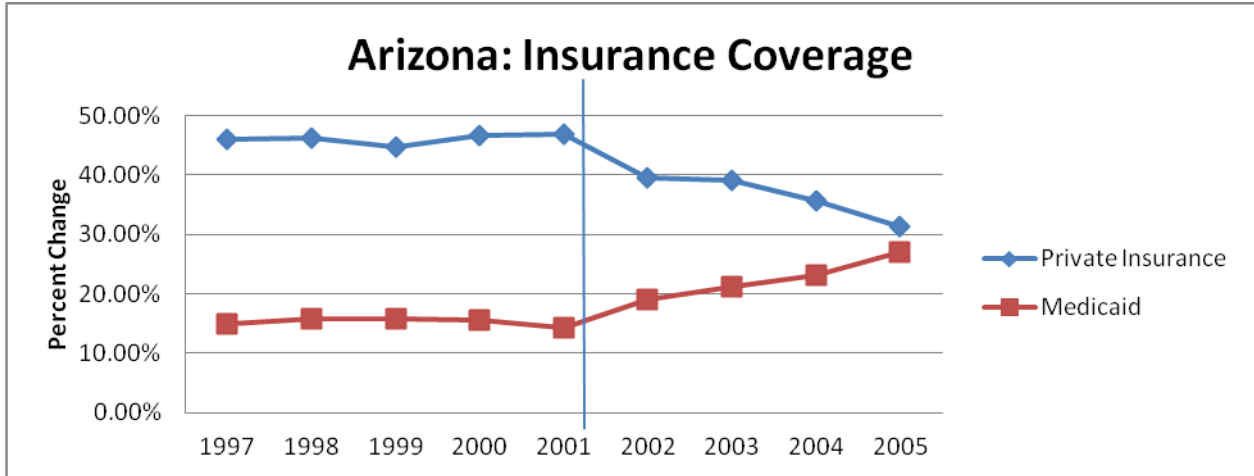
**Table 9**

Dependent Variable: Uncompensated Care Discharges  
Sample: 1997-2005  
Observations: 9

<b>Explanatory Variable</b>	<b>Estimated Coefficient</b>	<b>Standard Error</b>	<b>t Ratio</b>	<b>p Value</b>
Total Population (PopT)	0.003	0.004	0.92	0.387
Total Population on Medicaid (PopM)	0.005	0.006	0.92	0.387
Unemployment (Unem)	0.017	0.031	0.55	0.601
Undocumented Immigrant Population (Iimm)	0.012	0.021	0.56	0.633
Private Insurance Discharges (PriD)	-0.052	0.065	-0.81	0.447
Medicaid Discharges (MedD)	0.034	0.031	1.08	0.317
Age 18-44 Discharges (AgeD)	0.048	0.065	0.74	0.481

During my analysis I observed an interesting phenomena that may be of importance in determining if a state should undergo a Medicaid expansion like the one proposed for 2014.

Table 10

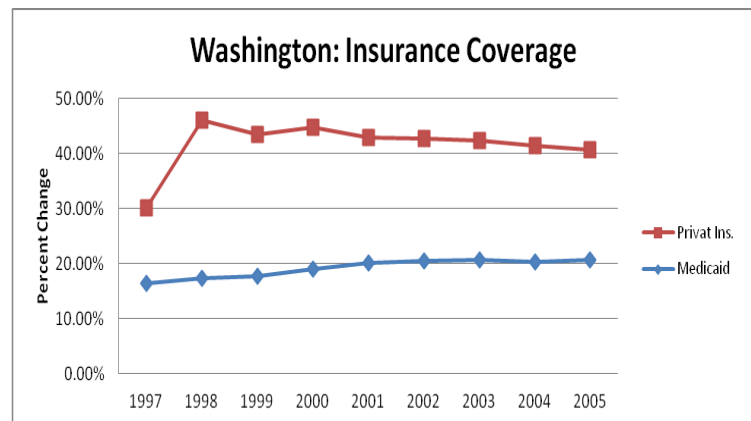
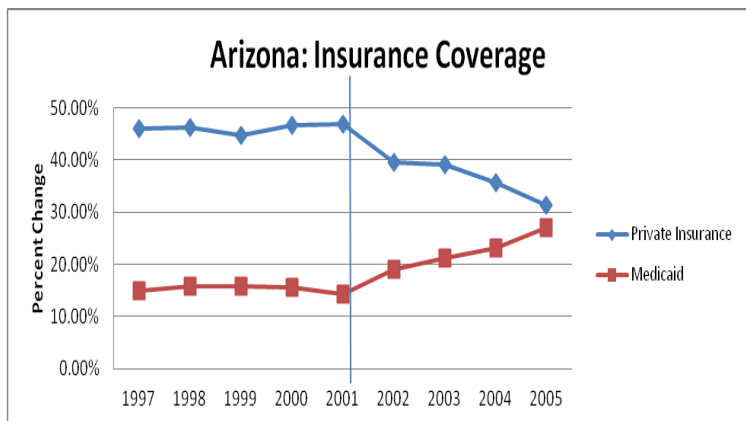
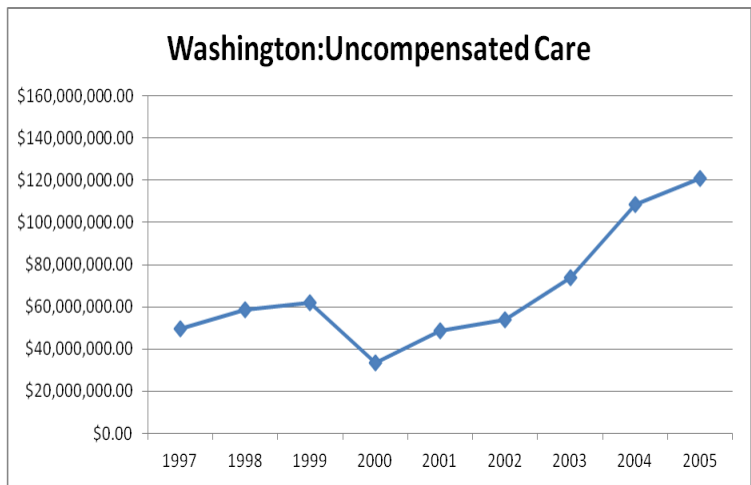
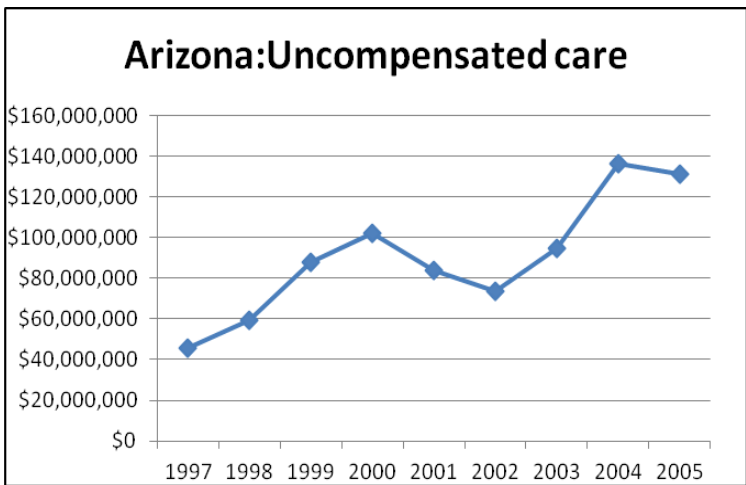
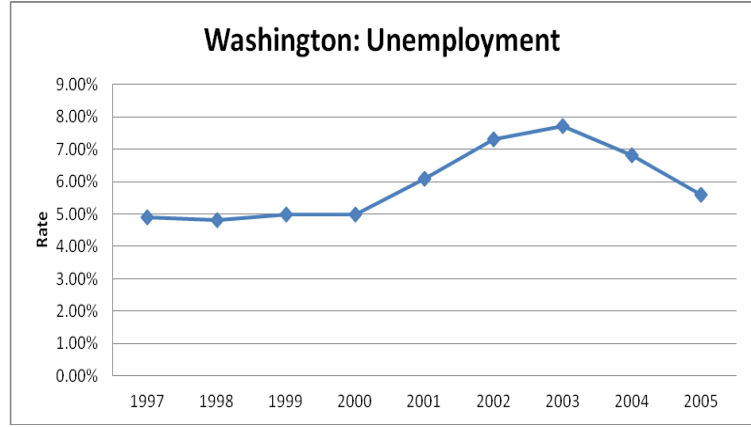
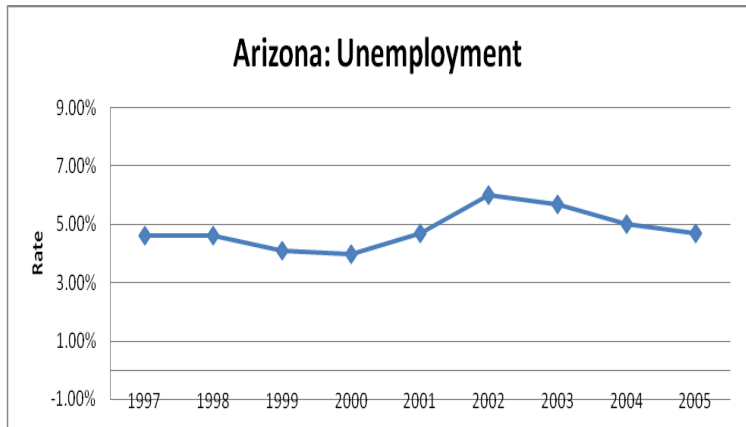
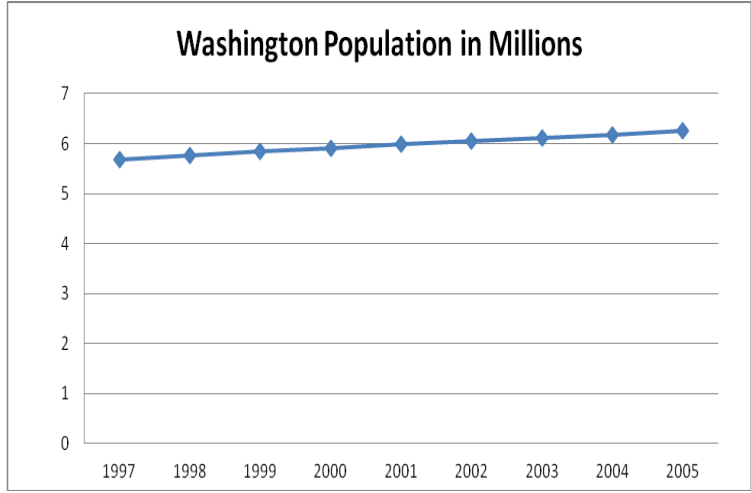
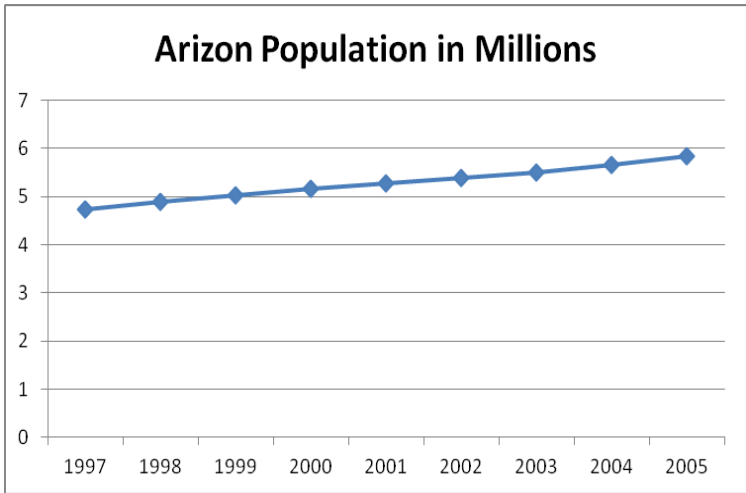


Data from HCUP

Table 10 indicates a potential “crowd out” situation that could have happened by insuring this specific population. Of course other economic issues were happening congruently, but data from previous research notes the possibility of crowd out in these situations. These other studies have suggested extending Medicaid to families above the poverty threshold has resulted in large increases in the number of people obtaining Medicaid, while dropping their private insurance. Estimates from these studies (Gruber and Cutler 1996 and Gruber and Simon 2008) indicate the phenomena could be rather large approaching 60% in one study and 50% in a similar study looking specifically at Medicaid Expansions in the Past.<sup>55</sup>

To try and determine the validity of the policy effect I looked at the state of Washington as a control. (Table 11) Washington had similar population growth and unemployment rates during the same time frame. The insurance coverage in the Washington group without the policy change showed no effect of uninsured “crowd out.” It is possible the “crowd out” may be attributable to the state of Arizona’s 2001 Medicaid expansion

Table 11



## Limitations

While analyzing uncompensated care charges as a tangible method for determining the potential for cost savings to a particular state's Medicaid program, it is not the only method, and it may not have as significant an impact as other potential issues, and therefore should not be a solitary predictor of a state's decision on whether or not to adopt the Medicaid expansion. I used this method and data because it was available and in a workable form for analysis. Unfortunately, there was not enough observations to do a proper regression analysis to determine the variables that have a causative effect on uncompensated care, therefore there are a lot of unanswered questions. Also, the data I used was aggregate data from all the hospitals in the State of Arizona, making it nearly impossible to determine if the data was based on the same observations from year to year or if there were potential individual hospital policy changes that may have had an affect uncompensated care. Overall, data on total discharges and total insurance coverage are a somewhat accurate depiction of year to year changes, but what happens if there is a major shift in healthcare access issues. What if a hospital or a large physician group closes from one year to the next? That kind of change certainly would have an effect on rates of care and change the potential for uncompensated care charges. A patient may go directly to a hospital instead of going to primary care doctor because of an access issue and may incur a higher out of pocket expense at the Emergency Room. Furthermore, it would be helpful to have diagnostic data to parse out reasons and charges for the hospital visits to get a more detailed understanding of the overall healthcare costs incurred by uninsured patients.

Also, the number of newly insured in the Arizona Medicaid population was smaller than that expected in the 2014 Medicaid expansion which could cause potential analysis problems. Furthermore, the uninsured discharges were aggregately assessed in one uncompensated care total, whereas other studies on Medicaid expansion had their uncompensated care data separated into

charity care and bad debt. Also, because of lack of more comprehensive data, an assumption was made that the uninsured accounted for all of the uncompensated care costs, and while that number may be extremely high, over 90% according to Holahan (2012), it is not completely accurate. Also, assumptions were made about the states specific percentage of state funding to support charity care. A rate of 30% was used based on the national average attested in the Kaiser Commission paper on Cost and Coverage Implications of the ACA Medicaid Expansion (Holahan 2012), but could have fluctuated from year to year. Further research using more comprehensive data would be suggested before drawing any conclusions with a potential impact on a healthcare policy decision.

## **Conclusion**

The proposed Medicaid expansion under the Patient Protection and Affordable Care Act is a topic that covers a large area of research and provides a plethora of argument from an infinite number of sources. Twenty one states have already decided to participate in the program, ten states are considering, and four (including Kentucky) are leaning towards participating with the remaining fifteen showing strong opposition. Overall, in nearly all of the states, this topic has been explored and the costs and benefits measured. One side of the debate believes insuring more of those without medical coverage could be financially beneficial to the states and the general economy. On the other side, those opposed fear the already overexposed state and federal budgets could explode under a newly added expenditure.

Many believe the new expansion in the immediate future will be a casualty of adverse selection, where the sickest uninsured Americans will be the first to utilize new services while the healthier uninsured will laggardly participate. Some states that are already providing services to the childless uninsured are finding that adult enrollees have greater health needs than expected. In

Arizona, higher than expected chronic illness and co-morbidities have caused the new adult childless Medicaid population to be three times more expensive than the parent Medicaid population.<sup>56</sup> Similarly, Indiana and Pennsylvania both experienced new enrollees with higher than expected health needs.<sup>57</sup>

A large majority of people also believe our society in general could benefit from this expansion, both in overall group health and economically. Preventative services and access to care for more Americans can be beneficial for society, because it will be easier to control lifestyle diseases through more inexpensive “well-care” provision. Secretary of Health and Human Services, Kathleen Sebelius, indicated hospital and patient groups are beginning to understand the economic advantages of the Medicaid expansion. More uninsured people will have basic coverage and the number of unpaid hospitalizations would be dramatically reduced. Secretary Sebelius also said the average American typically pays an extra \$1000 a year in insurance premiums to cover the costs of the uninsured at hospitals.<sup>58</sup>

Others are arguing the strain on the individual state budgets will produce an unaffordable situation to already struggling states. That was the main crux of opposition from government offices headed by Rick Perry of Texas, Bobby Jindal of Louisiana and Nikki Haley of South Carolina. Governor Perry, has stated the Medicaid system is broken and does not work. The federal costs of the program expanded 445% from 1990-2010 while in the same period enrollment only increased by 135%. Furthermore, he believes based on recent economic saving actions from the government spurred by budget deficit reduction plans, the monies the federal government is promising will not be available in the future.<sup>59</sup>

It is important to keep in mind that there are plenty of stakeholders active in the debate, protecting their enterprises. Hospitals could have a strong incentive for rallying behind the Medicaid expansion for two reasons. First, hospitals in states with expanded Medicaid coverage

could see increases in revenue from the increase in insured patients and reductions in uncompensated care. Although, I have not proven the reduction in uncompensated care, the hospitals in the state of Arizona did see a significant increase in their compensation following the policy change. (Table 7) Second, the Affordable Care Act calls for reduced reimbursement for hospitals in return for the expanded coverage to more Americans.<sup>60</sup> Due to other changes in the ACA, hospitals could still suffer reduction in payments from the federal and state government without the benefit of the expanded numbers of newly insured patients. According to the Affordable Care Act, the federal government will be reducing DSH payments to the states starting in 2014 by 25% and consequently reaching a 75% reduction by the year 2020. These reductions are planned to happen regardless of the state's implementation of the Medicaid expansion. Cuts to federal Medicaid DSH funding are estimated to be \$18.1 billion and Medicare DSH funding adds another \$22.1 billion over the years 2014–2020.<sup>61</sup> Furthermore, the President's Fiscal Year 2013-2014 budget proposed an additional \$8.25 billion in Medicaid DSH cuts for 2021 and 2022.<sup>62</sup> Consequently, governors and state legislators should expect their state's hospitals and clinics to lobby them for more—not less—state funding to replace reduced federal support.

Other groups potentially supporting the expansion are certain commercial insurance groups, primary care physicians and pharmaceutical companies. Insurance carriers support Medicaid expansion because they understand that hospitals could otherwise shift more uncompensated care costs to them. In the past, physician Medicaid reimbursement rates were low relative to Medicare rates. Most physicians received reimbursement between 65-80% of that received for Medicare and therefore were very selective in treating Medicaid patients.<sup>63</sup> Hence, primary care physicians are expected to get higher reimbursement rates for treating Medicaid patients under the ACA making treating the population potentially more attractive.



Based on what I have researched and studied in preparing this analysis I believe there are several factors that need to be considered by our governor in making the decision on whether to expand Medicaid. First, it is important to understand and justify the costs of the newly covered population even though the federal government will be picking up a majority of the cost of care. After assessing the information concerning uninsured hospital care, I believe several topics need to be discussed in order to give a solid recommendation on whether the policy should be considered for the Commonwealth of Kentucky. A cost benefit analysis needs to be done, looking at the potential cost savings (or losses) if Kentucky were to add approx. 240,000 people to the state Medicaid roles. Also, it is very important to understand the financial impact that will be felt from a potential reduction in the funding from the states and federal government for uncompensated “charity care” currently given to hospitals. Third, it will be important to quantify and understand the fiscal implications of the “Woodwork effect” that could potentially result from increased noise about Medicaid enrollment. Demand for existing programs could cause a further drain on state resources. For example in Wisconsin, they found when individuals were coming into the health and human services office for new Medicaid coverage many found out they were eligible for food benefits as well, therefore the state of Wisconsin saw a significant increase in its FoodShare participation.<sup>64</sup> Keep in mind increases in other already offered services could be potentially impactful to the state’s budgets, because these services will be paid for by the states at a much higher rate than that being offered under the new Medicaid expansion (approx. 30% on average compared to 10%).

Also, I believe that general information can be gathered to get a general idea of the economic impact of adding new federal dollars to the state of Kentucky’s economy. A Medicaid expansion could possibly inject new money into Kentucky’s healthcare industry and the economy in general. It may be important to try and understand the cost /benefit and implications regarding

potential tax benefits procured from the influx of new money from the federal government into the state budget. Lastly, it will be integral to explore the implications of the state not expanding Medicaid and therefore having some of the currently uninsured be covered by the new insurance coverage policies mandated by the new laws pertaining to the Affordable Care Act. If a state does not adopt the expansion, then individuals with incomes at or above 100 percent of FPL will instead qualify for the new federal exchange subsidies.

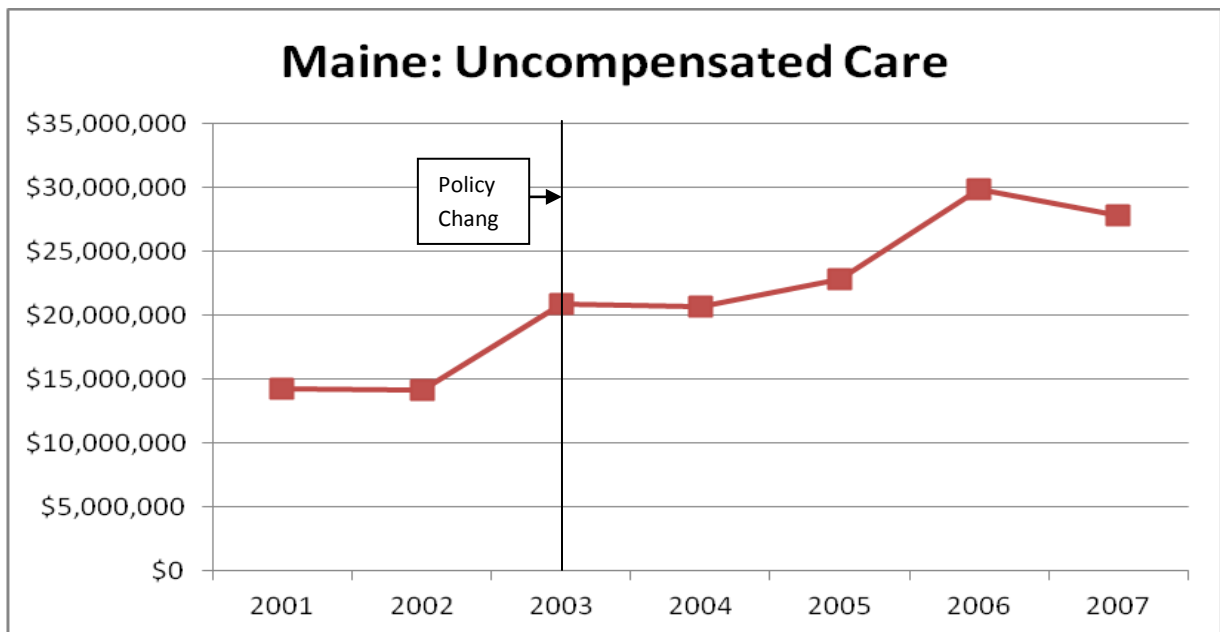
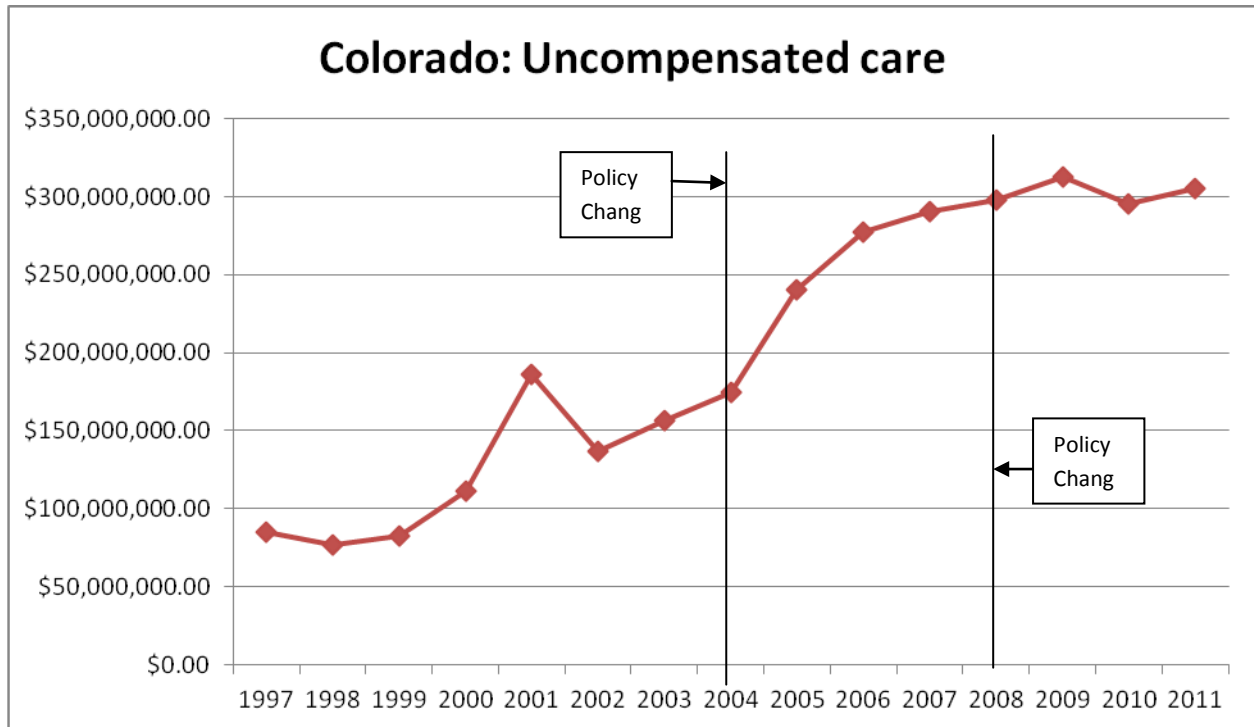
### Recommendation

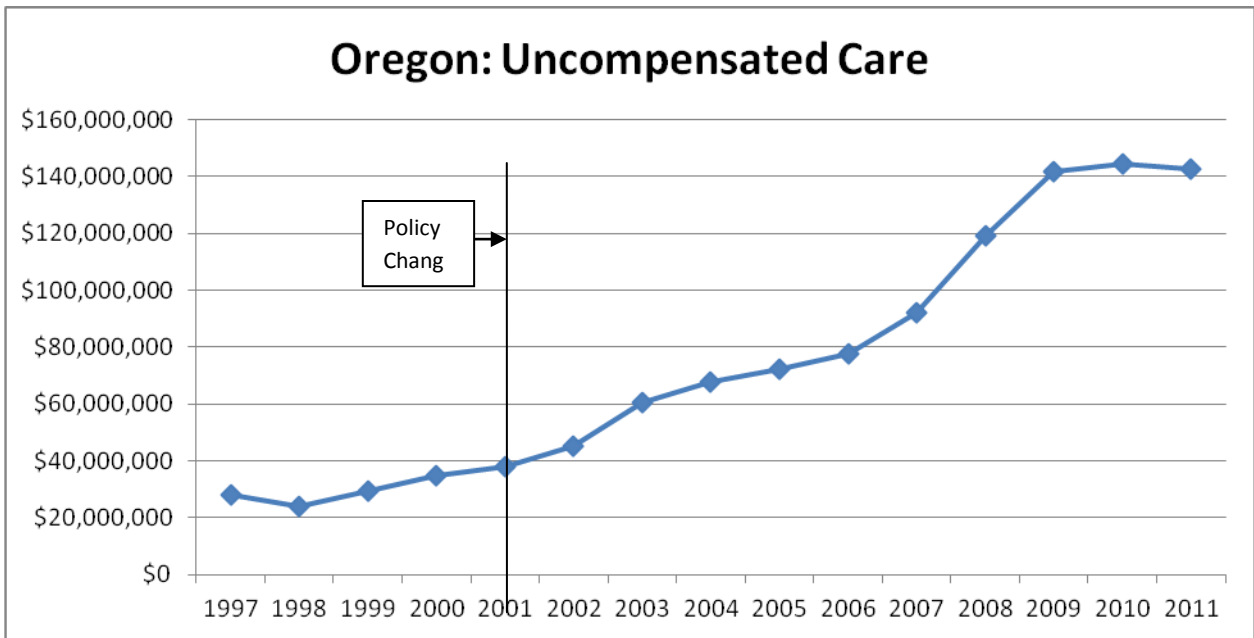
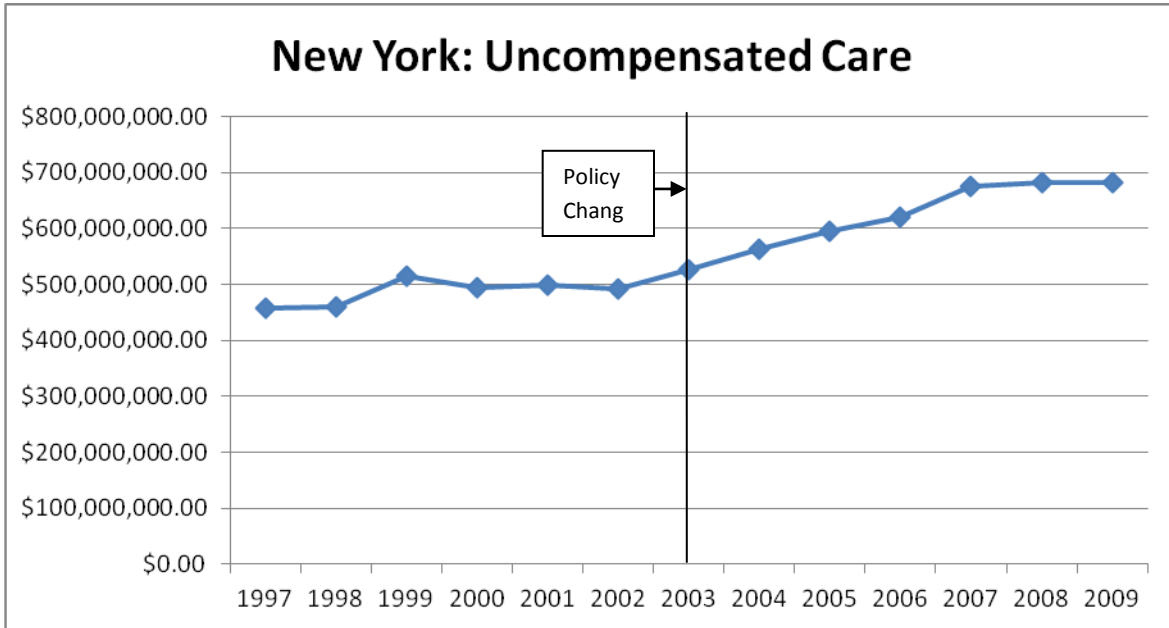
Overall, the results from my analysis seem to be insignificant and inconclusive. I studied Arizona to see if newly imposed state Medicaid share costs would be relieved by reducing state payments to uncompensated hospital care. There was no supportive data in my Arizona study that showed how increasing Medicaid insurance coverage to more uninsured citizens would reduce uncompensated hospital care. Other studies, including the New Jersey and Wisconsin trials, have shown reductions in uncompensated care costs and therefore provide evidence for more research. Many other factors are involved in determining a cost and benefit for implementing the Medicaid expansion and some have shown positive results, while others have drawn negative conclusions. I believe healthcare is important to nearly everybody and necessary for everyone. In Appendix 1. I have included graphs of other states that implemented a Medicaid expansion. These graphs were made using the same data as the Arizona study, so therefore they fall under the same data limitations discussed previously. I used similar HCUP discharge data to ascertain uncompensated care costs based on 2005 dollars using CPI. Also, I used a 30% rate as an average determinant for state share of uncompensated care costs. In looking at the graphs, similar conclusions could potentially be drawn, in that other factors including the national economic downturns were potentially determinants in causing more unrecovered hospital costs. In all of these states

Medicaid was provided to more citizens who previously were uninsured and yet uncompensated hospital care costs escalated. In looking at this data, one could suggest the policies did not make a significant impact. This data cannot be easily extrapolated to understand the impact of how a larger more comprehensive Medicaid expansion could benefit states and potential cost containment. I believe more study needs to be undertaken to understand other variables and their potential to skew the results.

Costs of the entire system are growing rapidly out of control. That is why I believe healthcare policies are measures that should be thought about carefully and researched sufficiently. Hence, I believe this subject deserves more analysis and time.

### Appendix 1





Data from HCUP hospital discharges, CPI index, \*Assistant Secretary for Planning and Evaluation ASPE. US Dept of Health and Human Services.

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<sup>1</sup> Todd, S. Sommers, B. Overview of the Uninsured in the United States: A Summary of the 2012 Current Population Survey Report. Sept. 12, 2012. ASPE.hhs.gov. Issue Brief U.S. Department of Health and Human Services.

<sup>2</sup> Holahan, John and Headen, Irene. Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL, Urban Institute and Kaiser Family Foundation, May 2012. (<http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf>)

<sup>3</sup> Alessi, Ryan. The Chatter: Poll Says Ky favors Medicaid Expansion; 1/23/2013, C/n2. <http://mycn2.com/politics/the-chatter-poll-says-ky-favors-medicaid-expansion-uk-s-survey-shows-equine-industry-worth-23-bil>

<sup>4</sup> Hightower, A. Beshear Simply Wrong. March 28, 2011. KY Club for Growth. [www.kyclubforgrowth.org/blog-mt/mt-tb.cgi/1142](http://www.kyclubforgrowth.org/blog-mt/mt-tb.cgi/1142)

<sup>5</sup> Bachrach, D. Dutton, M. The Role of the Basic Health Program in the Coverage Continuum: Opportunities, Risks, and Considerations for States. March 2012. The Kaiser Family Foundation. [www.kff.org](http://www.kff.org)

<sup>6</sup> Holahan, J. Buettgens, M, Carroll, C. Dorn, S. The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis. Nov. 2012. The Urban Institute.

<sup>7</sup> Alessi, Ryan. The Chatter: Poll Says Ky favors Medicaid Expansion; 1/23/2013, C/n2. <http://mycn2.com/politics/the-chatter-poll-says-ky-favors-medicaid-expansion-uk-s-survey-shows-equine-industry-worth-23-bil>

<sup>8</sup> Medicaid.gov <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html>

<sup>9</sup> NHE Fact Sheet 2011. CMS.gov. Centers for Medicare and Medicaid Services.

<sup>10</sup> Holahan, John. Buettgens, Matthew. Carroll, Caitlin, Dorn, Stan. The Cost and Coverage Implications of the ACA Medicaid Expansion: A National and State-by-State Analysis. The Urban Institute Nov.26, 2012: 1-61

<sup>11</sup> Ibid

<sup>12</sup> Data from U.S. Bureau of Labor Statistis. Mar. 13, 2013

<sup>13</sup> Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 current population survey.

<sup>14</sup> Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey

<sup>15</sup> Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey

<sup>16</sup> Holahan, J. Pelletier, J. The Health Status of New Medicaid Enrollees Under Health Reform. 2010. Urban Institute.

<sup>17</sup> Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey

<sup>18</sup> Elmendorf, DW. Statement of Douglas W. Elmendorf, Director: CBO's Analysis of the Major Health Care Legislation Enacted in March 2010. Washington (DC): Congressional Budget Office; Mar. 30, 2011.

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<sup>19</sup> Streeter, S., Licata, R., Newkirk, V., et al. The Uninsured: A Primer. Key Facts About Americans Without Health Insurance. Kaiser Commission on the Medicaid and Uninsured. Oct. 2012 Kaiser Family Foundation. <http://www.kff.org/uninsured/upload/7451-08.pdf>

<sup>20</sup> Kaiser Family Foundation estimates based on 2009 Medical Expenditure Panel Survey (MEPS) data.

<sup>21</sup> (Kaiser)

<sup>22</sup> Wilper, et al., 2009, "Health Insurance and Mortality in US Adults." American Journal of Public Health, 99(12) 2289-2295.

<sup>23</sup> The Kaiser Commission on Medicaid and the Uninsured. Ensuring Access to Care in Medicaid under Health Reform. May 2011. [www.kff.org](http://www.kff.org).

<sup>24</sup> Unpublished data, Kenney, J. Lynch, V. Haley, J. Huntress, M. (2012). Washington, DC. Urban Institute.

<sup>25</sup> Currie, J. The Take-up of Social Benefits. 2004. Cambridge, MA. NBER

<sup>26</sup> Davidoff, A. Yemane, A. Adams, E. Health Coverage for Low-Income Adults: Eligibility and Enrollment in Medicaid and State Programs, 2002. 2005 Kaiser Commission on Medicaid and the Uninsured.

<sup>27</sup> Sommers, B.D. Swartz, K. Epstein, A. Policy Makers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs, and Needs for Physicians under Health Reform. 2011 Health Affairs. 30(11): 2186-2193

<sup>28</sup> Holahan, J. Headen, I. Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. 2010 Washington (DC): Kaiser Commission on Medicaid and the Uninsured.

<sup>29</sup> Centers for Medicare and Medicaid Services. Office of the Actuary (2010). 2010 Actuarial report on the financial outlook for Medicaid. Baltimore, MD.

<sup>30</sup> Dorn, S. Uninsured and Dying Because of it: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality. Jan. 2008. The Urban Institute. Washington (DC).

<sup>31</sup> Holahan, J. Kenney, G. Pelletier, J. The Health Status of New Medicaid Enrollees Under Health Reform. August 2010. The Urban Institute.

<sup>32</sup> Ibid

<sup>33</sup> Finkelstein A, et al. 2011, The Oregon Health Insurance Experiment: Evidence From the First Year, National Bureau of Economic Research. Available at <http://www.nber.org/papers/w17190>.

<sup>34</sup> Sommers BD, Baicker K, and Epstein AM. Mortality and Access to Care Among Adults After State Medicaid Expansions. The New England Journal of Medicine. 2012

<sup>35</sup> Epstein, Arnold, Newhouse, Joseph. Impact of Medicaid Expansion on Early Prenatal Care and Health Outcomes. Health Care Financing Review. Summer 1998 vol. 19, No 4.

<sup>36</sup> Ibid

<sup>37</sup> Families USA.org. Fact Sheet. Enrollment Policy Provisions in the Patient Protection and Affordable Care Act. 1-6

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<sup>38</sup> U.S. Department of Health and Human Services. Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for FY 2012

<sup>39</sup> Urban Institute Analysis, HIPSIM 2012

<sup>40</sup> Stoll, K, Bailey, K. Jobs at Risk: Federal Medicaid Cuts Would Harm State Economies. June 2011  
www.familiesusa.org.

<sup>41</sup> Ibid

<sup>42</sup> Hadley, J, Holahan, J. The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medicaid Spending? May 10, 2004 Kaiser Commission on Medicaid and the Uninsured.

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