



Ohio Medicaid Group VIII Assessment:

A Report to the Ohio General Assembly

The Ohio Department of Medicaid

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Executive Summary: The Ohio Medicaid Group VIII Assessment

a. What is the Ohio Medicaid Group VIII Assessment?

House Bill 64 of the 131st General Assembly required the Ohio Department of Medicaid to provide a report evaluating the impact of Ohio's 2014 Medicaid expansion. Guided by the General Assembly's request, the Ohio Medicaid Group VIII Assessment examined how Medicaid expansion has affected new enrollees with respect to access and utilization of health care, physical and mental health status, financial distress/hardship, and employment.

The phrase "Group VIII" refers to the section of the Social Security Act that sets requirements for Medicaid expansion eligibility and allowed most Ohioans age 19 through 64 with incomes at or below 138% of the federal poverty level (FPL) to become eligible for Medicaid. Prior to January 1, 2014, Medicaid eligibility for adults was limited to those with certain qualifying characteristics such as parenthood or disability, and the income limitation for most Medicaid eligibility groups was lower than 90% of the FPL.

b. Who is Included in the Ohio Medicaid Group VIII Assessment Study?

The Ohio Medicaid Group VIII Assessment examined the effects of Ohio's 2014 Medicaid expansion on recipients enrolled through the Group VIII criteria ("Group VIII enrollees"). When appropriate, Group VIII enrollees were compared to those enrolled in Ohio Medicaid under pre-expansion eligibility rules ("pre-expansion enrollees"). Administrative data from the Ohio Department of Medicaid were used to identify eligible persons, and study participants were selected using stratified random sampling techniques. To enable comparison between Group VIII enrollees and the pre-expansion comparison group, the study excluded those enrolled as dual eligible, pregnant, living in institutions, or with less than 11 months continual enrollment (a full list of exclusion criteria is included in the Methodology Report).

c. How was the Ohio Medicaid Group VIII Assessment Conducted?

The Ohio Medicaid Group VIII Assessment is one of the nation's most comprehensive assessments of a state's Medicaid expansion. The assessment used the following methods to collect data:

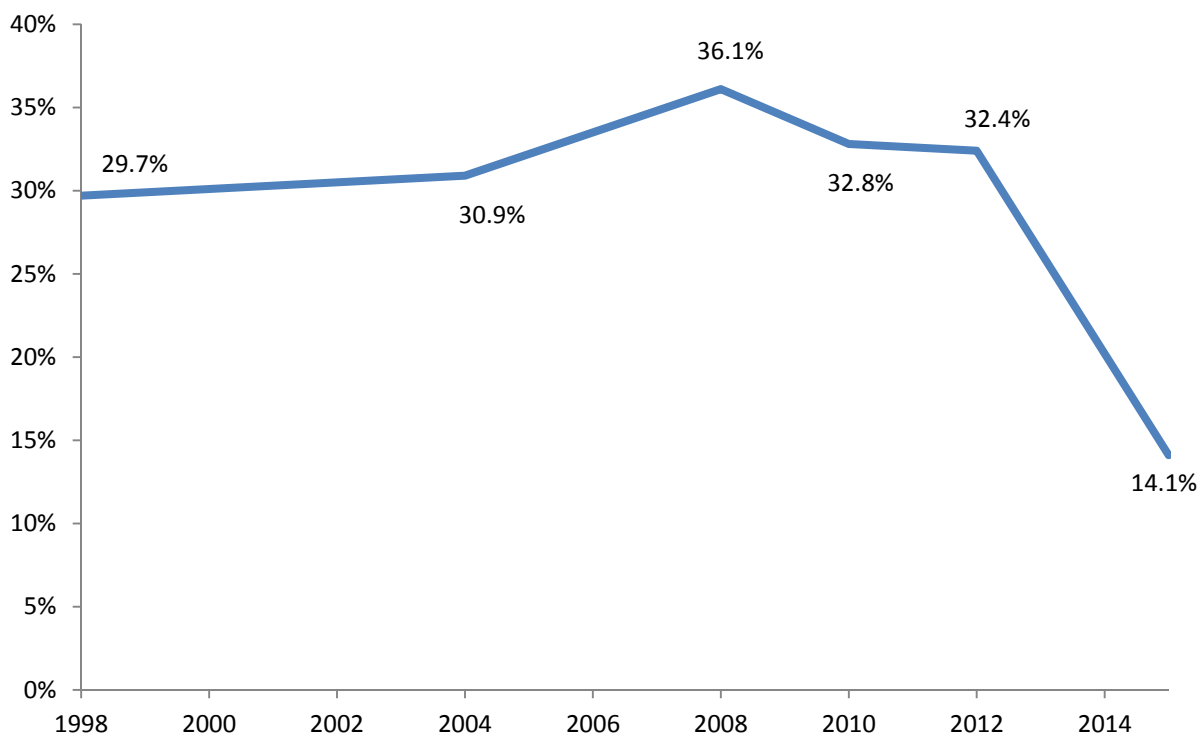
- A detailed telephone survey of 7,508 Group VIII and pre-expansion enrollees, including questions about access to care, health system utilization, physical and mental health, financial hardship, and employment (cooperation rate of 76.1%).
- A biometric screening of 886 respondents who completed the telephone survey, including both Group VIII and pre-expansion enrollees. The biometric screenings allowed for the systematic collection of comprehensive and verifiable health-related data (screening response rate of 68%).
- A review of the medical records of 430 Group VIII enrollees who completed the telephone survey and biometric screening. Collected records spanned the time periods before and after Medicaid enrollment and enabled an assessment of how health care utilization, health status, and medical treatments changed after enrolling in Medicaid.
- An analysis of Medicaid administrative data for all Group VIII and pre-expansion enrollees eligible for the Group VIII Assessment. The review of administrative data was used to calculate measures of health care utilization, including preventive care and evidence-based care for chronic health conditions.
- Focus groups of 27 Group VIII enrollees who participated in the telephone survey at a minimum (some participants completed other components as well). Focus groups were designed to obtain more in-depth and personalized information about survey responses.

- Interviews with 10 Ohio Medicaid service providers and other key stakeholders. These interviews allowed for input from Medicaid stakeholders on the effects of Medicaid expansion.

d. What are the Key Findings of the Ohio Medicaid Group VIII Assessment?

The Group VIII Population (Section II of the Report)

Percentage of Ohioans Age 19-64 with Family Income at or below 138% Federal Poverty Level without Insurance from 1998-2015



Source: Ohio Medicaid Assessment Survey.

1. At the close of sample selection, May 2016, a total of 702,000 individuals were eligible for and received Group VIII Medicaid coverage.ⁱ
2. Findings from the 2015 Ohio Medicaid Assessment Survey indicate that Medicaid expansion contributed to a large decline in the uninsured rate for low-income non-senior adults in Ohio ($\leq 138\%$ of the FPL) to the lowest rate ever recorded (14.1%).
3. Most Group VIII enrollees were uninsured prior to obtaining Medicaid coverage, either because they had no prior insurance at all (75.1%) or they had lost employer-based insurance (13.9%).
4. Most Group VIII enrollees were white (71.5%), male (55.8%), with a high school degree or less (58.1%), unmarried (83.8%), and without a child in the home (82.1%). Employment rates were similar for Group VIII and pre-expansion enrollees (43.2% versus 41.5%).
5. As a result of being older (51.4% age 45 and older) and more often male than pre-expansion enrollees, Group VIII enrollees had slightly higher rates of health risk indicators—such as high blood pressure

ⁱ This number includes retroactive and backdated enrollments for May processed through November. See the Methodology Report for details regarding enrollment calculations.

and high cholesterol—and higher rates of chronic disease diagnoses than the younger and more often female pre-expansion enrollees.

Health System Access and Utilization (Section III of the Report)

6. Group VIII enrollees overwhelmingly reported that access to medical care had become easier since enrolling in Medicaid—these gains were largest for those who were previously uninsured.
7. For many Group VIII enrollees, improved access to care was associated with a reduction in unmet medical needs. Nearly half of Group VIII enrollees (43.3%) reported a decline in unmet health care needs, while only 8.3% reported an increase, with the remainder reporting no unmet needs or no change in the level of unmet needs.
8. Emergency department use, which is often a very costly form of care, decreased for Group VIII enrollees. Survey results and medical records analyses showed that Group VIII participants were better integrated into the health care system, increasingly connecting to a usual and appropriate source of health care.

Physical Health (Section IV of the Report)

9. Nearly half of Group VIII enrollees (47.7%) reported improvement in their overall health status since enrolling in Medicaid, compared to 3.5% who said their health had worsened.
10. After obtaining Medicaid coverage, 27.0% of Group VIII enrollees were diagnosed with at least one chronic health condition. These new diagnoses, alongside widespread reports of improved health access, suggest that Group VIII enrollees have become more likely to receive needed appropriate care.
11. According to the medical records case study, the individuals studied had lower levels of high blood pressure or high cholesterol since enrolling in Medicaid.

Mental Health (Section V of the Report)

12. Based on a mental health screening of survey participants, about one-third of Group VIII enrollees (31.9%) and 35.7% of pre-expansion enrollees screened positive for depression or anxiety disorders, with these conditions limiting usual routine activities, including employment.
13. Since enrollment in Medicaid, 44.0% of Group VIII enrollees reported better access to mental health services.
14. Group VIII enrollees with depression and anxiety reported greater improvement in access to care (68.5%) and prescriptions (71.2%) than those without depression or anxiety (62.4% and 62.5%, respectively).
15. For Group VIII enrollees with a clinical diagnosis of depression, most (61.7%) received pharmacotherapy treatment consistent with acute care guidelines established by the National Committee for Quality Assurance that target continuous treatment with antidepressant medication during the first 12 weeks of care.
16. Group VIII participants were as likely as pre-expansion enrollees to be diagnosed with substance abuse or dependence (32.3% versus 33.8%, respectively) and to be diagnosed for opiate abuse and dependence (3.6% for each group). However, Group VIII enrollees were less likely to receive

prescriptions for medications associated with abuse and dependence, such as opioids and benzodiazepines (25.6% versus 32.0% for opioids, 10.4% versus 13.6% for benzodiazepines). This finding is consistent with prior Ohio Department of Medicaid analyses demonstrating reductions in opioid prescribing for pain conditions concurrent with opioid prescribing reform measures.

17. Group VIII enrollees with opioid use disorders reported greater improvement in their access to care than other Group VIII enrollees (75.4% versus 64.0% for overall access to care; 82.7% versus 64.8% for access to prescription medications; and 59.3% versus 32.2% for access to mental health care). Employment and Financial Hardship (Section VI of the Report).
18. Most study participants reported that enrollment in Medicaid made it easier to work and to seek work. Three-quarters of the Group VIII enrollees (74.8%) who were unemployed but looking for work reported that Medicaid enrollment made it easier to seek employment. For those who were currently employed, 52.1% reported that Medicaid enrollment made it easier to continue working.
19. Group VIII enrollees were more than twice as likely to report improvements in their financial situation rather than declines in financial well-being. In particular, Medicaid enrollment enabled participants to meet other basic needs. More than half of Group VIII enrollees (58.6%) reported that it was now easier to buy food, 48.1% stated that it was easier to pay their rent or mortgage, and 43.6% said it was easier to pay off other debts.
20. The percentage of Group VIII enrollees with medical debt fell by nearly half since enrolling in Medicaid (55.8% had debt prior to enrollment, 30.8% had debt at the time of the study).

e. What are the Conclusions about the Impact of Medicaid Expansion in Ohio?

Ohio's Group VIII Medicaid expansion provided coverage to 702,000 low-income Ohioans in May 2016 (the sample date), the vast majority of whom were previously uninsured. Group VIII enrollees reported increased access to usual and appropriate sources of care, better management of chronic diseases and health risk factors, and reductions in emergency department use.

Importantly, many Group VIII enrollees were diagnosed with a previously unknown chronic health condition for which they are now able to seek care. Because they were able to obtain treatment for previously untreated conditions, several of the enrollees stated that they did not think they would be alive today if Medicaid expansion had not occurred. The review of medical records confirmed that many Group VIII enrollees experienced improved chronic disease and health risk factor management for conditions such as heart disease and depression resulting from appropriate access to statin prescriptions, antidepressant medications, and clinical health interventions. The medical records review also revealed an increase in the likelihood of a Group VIII enrollee visiting his or her medical provider at least twice annually.

In addition to the reduction in unmet medical needs, Group VIII enrollees also reported substantial declines in overall stress and financial hardship. Most Group VIII enrollees reported that Medicaid made it easier to seek employment or remain employed. During the focus group discussions, some participants mentioned that Medicaid allowed them to get treated for chronic conditions that prohibited them from working when they were uninsured.

A small percentage of Group VIII enrollees did report having unmet medical needs or challenges accessing certain services (e.g., dental care). Following up on these reports, when Group VIII researchers asked about access to care, providers and stakeholders confirmed challenges with the low Medicaid payment rates which limited the pool of providers, an issue that predates Group VIII Medicaid expansion. A specific challenge is provider beliefs

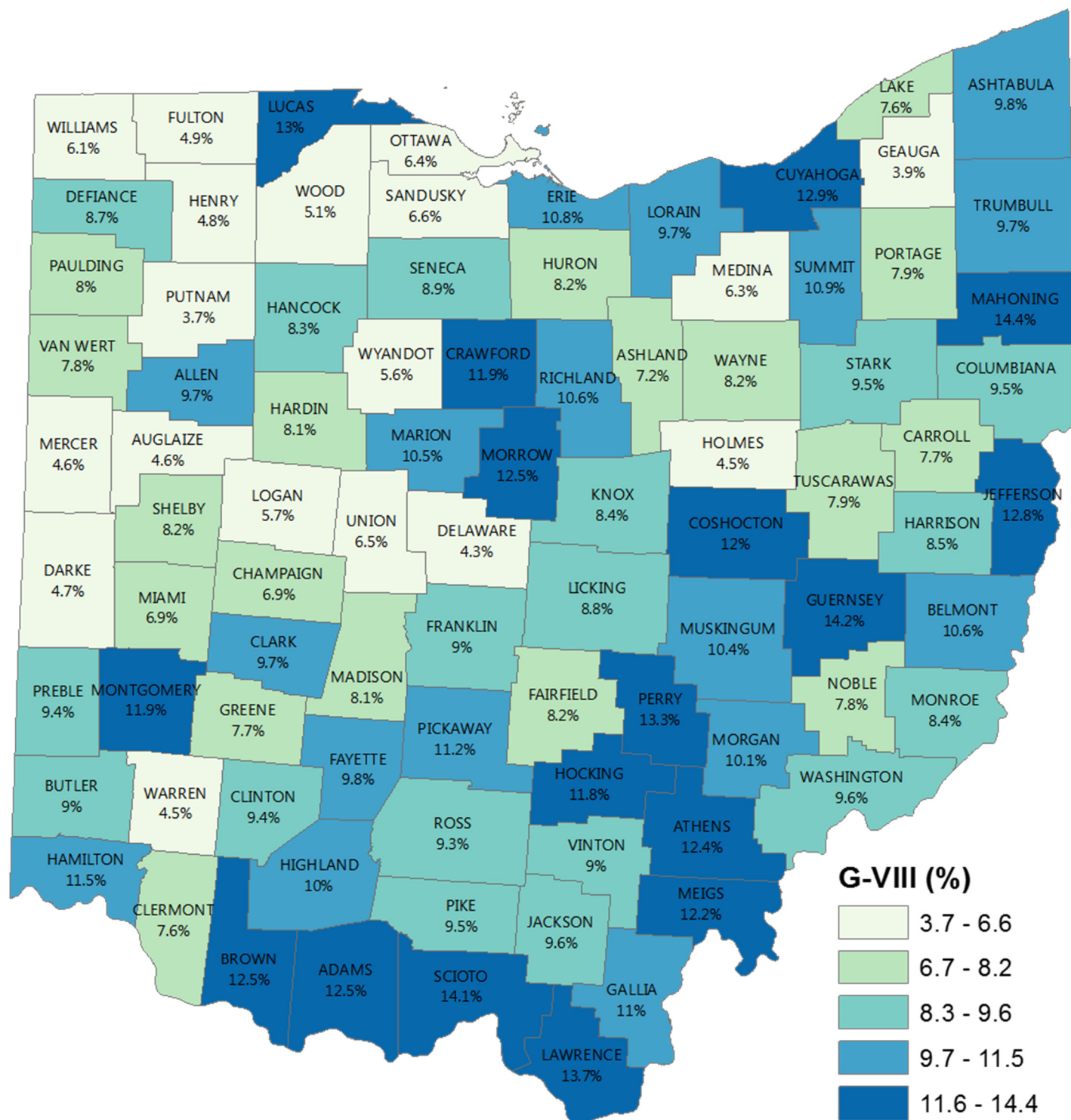
that more financial opportunities exist with other types of insurance reimbursement. These findings may indicate future opportunities for Medicaid to improve access to care for its members.

Generally, however, providers and stakeholders had a positive outlook on Medicaid expansion and reported that it had made access to and use of needed care considerably easier for their patients.

In summary, Medicaid expansion has been beneficial to Ohio Group VIII enrollees in terms of: (1) access to physical and mental health care; (2) health care utilization and reduced emergency department use; (3) detection of unknown or unaddressed prior health conditions (particularly chronic health conditions); (4) security of and opportunities for employment; (5) the lessening of family financial stress; (6) declines in medical debt-holding; and (7) an increase in the ability to pay other nonmedical bills (e.g., household utilities, food, transportation). These results are similar to studies in other states that have found Medicaid expansion to be associated with improved access to and utilization of needed medical care (California, Maine, Massachusetts), increases in general health statuses (Arizona, Maine, Massachusetts, Minnesota), and reduction in stress—including financial stress (Minnesota and Oregon), and more appropriate health care utilization (a review of all expansion states).

Finally, despite the short time elapsed since Medicaid expansion, Group VIII enrollees reported modest physical and mental health status gains, and most reported an increase in household, employment, and health security. Overwhelmingly, new enrollees reported being grateful for their Medicaid expansion health care coverage and valued having access to Ohio's health care system.

Percentage of All Adults 19-64 Years of Age Enrolled in the Group VIII Expansion, October 2016



Legend is set in quintiles from 0% to 100%; data source is Ohio Department of Medicaid Expenditure and Caseload Report (<http://medicaid.ohio.gov/Portals/0/Resources/Research/MedicaidEligExpReports/2016/Med-10.pdf>)

Medicaid (%)

- 6.7 - 13.1
- 13.2 - 16.3
- 16.4 - 19.1
- 19.2 - 22.2
- 22.3 - 30.4

County	Medicaid (%)
Ashtabula	20.6
Cuyahoga	23.9
Franklin	18.5
Lucas	25.8
Medina	11.4
Monroe	16.5
Shelby	14.5
Stark	18.4
Summit	19.4
Trumbull	17.8
Van Wert	16.1
Washington	18
Wayne	15.3
Willoughby	14
Wood	9.5
Yates	10.1
Adams	27
Allen	19.4
Auglaize	9.8
Brown	26.1
Butler	16.9
Champaign	13.7
Clermont	15.2
Crawford	24.8
Delaware	8.7
Darke	10.1
Defiance	17.9
Fulton	9.2
Gallia	23.5
Geauga	6.7
Hancock	16.3
Harrison	15.8
Holmes	8.7
Henry	9.6
Huron	16.7
Highland	22.2
Jefferson	23.9
Knox	16.6
Lake	14
Lorain	17.5
Licking	17.2
Lawrence	30.1
Madison	16.1
Marion	20.4
Mercer	9.3
Meigs	26.4
Miami	13.7
Montgomery	18.8
Moreno	24.1
Morgan	20.9
Muskingum	21.1
Noble	15.1
Portage	14.2
Perry	24.6
Pike	20.9
Putnam	7.9
Preble	18.8
Richland	20.8
Rocky	10.1
Sandusky	13.1
Scioto	30.4
Seneca	17.2
Shelby	14.5
Stark	18.4
Summit	19.4
Tuscarawas	16.1
Union	13
Van Wert	16.1
Warren	9.1
Washington	18
Wayne	15.3
Williams	13
Wood	9.5
Wyandot	11.3

The Ohio Department of Medicaid

I. Introduction

The Ohio Medicaid Group VIII Assessment report presents results from the first comprehensive study examining the effects of Medicaid expansion in Ohio. To date, no other single state has conducted an evaluation of Medicaid that is as extensive as the Group VIII Assessment.

House Bill 64 of the 131st General Assembly required the Ohio Department of Medicaid (ODM) to provide a report evaluating the effect of Ohio's 2014 Medicaid expansion. Guided by the General Assembly's instruction and at the request of the State Medicaid Director, the Ohio Medicaid Group VIII Assessment examined how Medicaid expansion has affected new enrollees with respect to access and utilization of health care, physical and mental health status, financial distress/hardship, and employment.

The data collected to produce this report included a 7,508-person telephone survey, biometric screenings, medical records reviews, analysis of Medicaid administrative records, and interviews with Medicaid enrollees and stakeholders. All of these data sources consistently demonstrated that Medicaid expansion in Ohio, in addition to providing health insurance coverage to 702,000ⁱⁱ low-income Ohioans in May 2016, has had positive effects on new enrollees' access to care, physical and mental health, and financial well-being. In survey responses, participants enrolled through the Medicaid expansion emphasized that Medicaid is critically important to their health status and socioeconomic security, with numerous respondents stating that Medicaid has literally saved their lives because of new access to physicians, dentists, mental health providers, and substance abuse treatment programs. Throughout this report, direct quotes from survey participants are presented in text boxes. These are responses to the survey question, "In your own words, describe in a sentence what getting Medicaid has meant to you."

"It gives me peace of mind knowing that I don't have to pay for the medical insurance, and it saves me money being able to afford food and utilities and everyday things you need in life."

"It's been a blessing and I thank God that I have Medicaid because I no longer have large payments and I can get my Medicaid medicines."

"More freedom. Less worries. I was an addict for 3 years before getting Medicaid. Because of Medicaid I'm not an addict."

Source: Group VIII Telephone Survey

1. Medicaid Expansion in Ohio and Report Terminology

Beginning January 1, 2014,ⁱⁱⁱ many Ohioans age 19 through 64 with incomes at or below 138% of the federal poverty level (FPL) (\$16,394 for a single adult in 2016) became eligible for Medicaid benefits under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. Prior to that date, most low-income adults in Ohio were ineligible for Medicaid unless they had an income that was generally below 90% FPL and also possessed certain other qualifying characteristics such as parenthood, disability, or pregnancy.

ⁱⁱ This number is unpublished and includes retroactive and backdated enrollments for May processed through November. The source for the estimate is ODM. See the Methodology Report for details regarding enrollment calculations.

ⁱⁱⁱ Although the Patient Protection and Affordable Care Act was signed in March 2010, Medicaid expansion in Ohio was initiated statewide as of January 1, 2014.

The population of adults newly eligible for Medicaid in Ohio is referred to in this report as Group VIII (referencing the section of the Social Security Act). The change in policy extending Medicaid eligibility to Group VIII is referred to as “Medicaid expansion.”

Those enrolled in Ohio Medicaid through Group VIII are referred to in this report as “Group VIII enrollees.” Those enrolled in Ohio Medicaid through other Medicaid programs that existed prior to Medicaid expansion are referred to as “pre-expansion enrollees.”^{iv} In the figures and charts included in this report, findings for Group VIII enrollees are presented in blue, while findings for pre-expansion enrollees are presented in gray.

2. Statutory Mandate

House Bill 64 of the 131st General Assembly required ODM to provide a report evaluating the effect of Medicaid expansion. Specifically, the statute requires:

Not later than January 1, 2017, the Ohio Department of Medicaid shall submit to the General Assembly, in accordance with section 101.68 of the Revised Code, a report evaluating the Medicaid program’s effect on clinical care and outcomes for the group described in section 1902(a)(10)(A)(i)(VIII) of the “Social Security Act,” 42 U.S.C. 1396a(a)(10)(A)(i)(VIII), including the effects on *physical and mental health, health care utilization and access, and financial hardship*.

This report and the accompanying Methodology Report and appendices were prepared in fulfillment of ODM’s statutory obligations. To assist in preparing this report, ODM contracted with the Ohio Colleges of Medicine Government Resource Center.

3. Literature Review

Recently the Kaiser Family Foundation released a literature review of 22 studies on the impacts of Medicaid expansion that were conducted between January 2014 and May 2016,¹ which assessed the influence of Medicaid expansion on access to care, utilization of services, and health outcomes.

These 22 studies either compared Medicaid expansion states to non-expansion states or examined the experience of one or more states’ populations before and after Medicaid expansion. Most of the studies reported statistically significant benefits from Medicaid expansion, although some did not find statistically significant benefits on some or all of the variables they studied. None of the studies found negative health-related outcomes resulting from Medicaid expansion. Studies released since May 2016 have reported similar findings.²

Given the relatively short time since Medicaid expansion, studies have not been able to determine whether these effects translate into long-term improvements in health outcomes. Answering this question will require longer-term research and can be examined as a follow-up to this assessment.

Key statistically significant findings from recent studies of Medicaid expansion include the following:

Increased Access to Medical Care, With Some Challenges

- Improvements in measures of access to health care, such as easier access to medications and more low-income individuals with a usual source of care^{2,3,4,5,6,7,8,9}
- Fewer people with unmet health needs and fewer people delaying or foregoing needed health care^{10,11}
- Increased availability of and access to behavioral health (mental health) services^{12,13,14}

^{iv} For the purposes of this report, “pre-expansion enrollees” refers to those who enrolled before January 1, 2014.

- Mixed findings on wait times to receive health services with some studies showing increased waiting times at some provider locations because of increased demand for services^{15,16} while others show wait times that are similar to pre-expansion Medicaid coverage or to other types of insurance^{7,17}

Utilization of Needed Medical Services

- Increased utilization of preventive, dental, and primary care physician services^{2,13,18}
- Increases in the percentage of individuals with chronic conditions obtaining regular care^{4,7}
- Fewer people skipping medications as prescribed, or non-adherent to prescribed medication regimen (either not filling a prescription or splitting the dose) because of cost^{4,6}
- An initial increase in overnight hospital stays⁹
- Mixed findings on emergency department (ED) visits with some finding increases,¹⁹ others finding no significant change,^{4,9} and others finding lower use within 2 years of expansion compared to people in non-expansion states²
- Some individuals receiving life-saving or life-changing surgeries they could not have received while uninsured¹²

Incremental Improvement in Health Status

- Increased diagnoses of previously unidentified health conditions, such as diabetes, high cholesterol, and cancer^{9,20}
- Modest improvements in self-rated health statuses, although some people reported poorer health status upon finding out they had previously unknown health conditions¹⁸
- Modest decreases in the number of work days missed because of poor health¹⁸
- Improvement in health and quality of life, with lower levels of stress after expansion (this study included focus groups with Ohioans from Columbus)¹¹
- Reported better health from people in expansion states compared to those in non-expansion states by 2 years after expansion²

Improvement in Financial Well-Being

- Improvements in financial security, including large declines in trouble paying medical bills^{3,4,21}
- Reductions in the amount of unpaid debt sent to collection agencies in zip codes with the highest proportion of low-income residents²¹

Studies on Medicaid expansion have employed a variety of research approaches, including surveys, focus groups, claims and utilization data analysis, and stakeholder interviews. No previous study combined all of the strategies into one comprehensive assessment. The Ohio Medicaid Group VIII Assessment, compared to other studies on Medicaid expansion, uses all of these research methods, along with medical records reviews and biometric screenings, to allow for a more comprehensive assessment of Medicaid expansion's impact on Ohioans.

4. Group VIII Study Design

The general goals of the Ohio Medicaid Group VIII Assessment were to determine whether gaining Medicaid coverage impacted the health and social circumstances of Group VIII enrollees and to understand how those who gained coverage were utilizing Medicaid coverage.

Using Medicaid administrative data, it was possible to identify everyone who had gained coverage through Medicaid expansion. This identification enabled the research team to draw a base sample of respondents from the latest enrolled Medicaid population.

After reviewing data collection possibilities, the Ohio Medicaid Group VIII Assessment research team decided on a staged approach to this assessment using multiple data collection modes. The main topic areas for measurement were: (1) access to health care services; (2) utilization of health care services, particularly for appropriate primary and preventive care; (3) financial distress associated with using health care services—particularly for the uninsured and underinsured; (4) current and future employment; (5) family financial security; (6) changes in health status; and (7) open-ended evaluations of what Medicaid expansion has meant to Group VIII enrollees.

The study design used five data collection modules (see Figure 1 below), with some Medicaid enrollees participating in multiple modules depending on random selection or voluntary consent as described below. When collected, these data were aggregated into a master data file with data linked at the respondent level, with the exception of the qualitative interviews.

The first module was a survey of Group VIII and pre-expansion enrollees that addressed health care access, use, and benefits through survey responses. Survey data were weighted and set to represent the total Group VIII and pre-expansion enrolled populations.

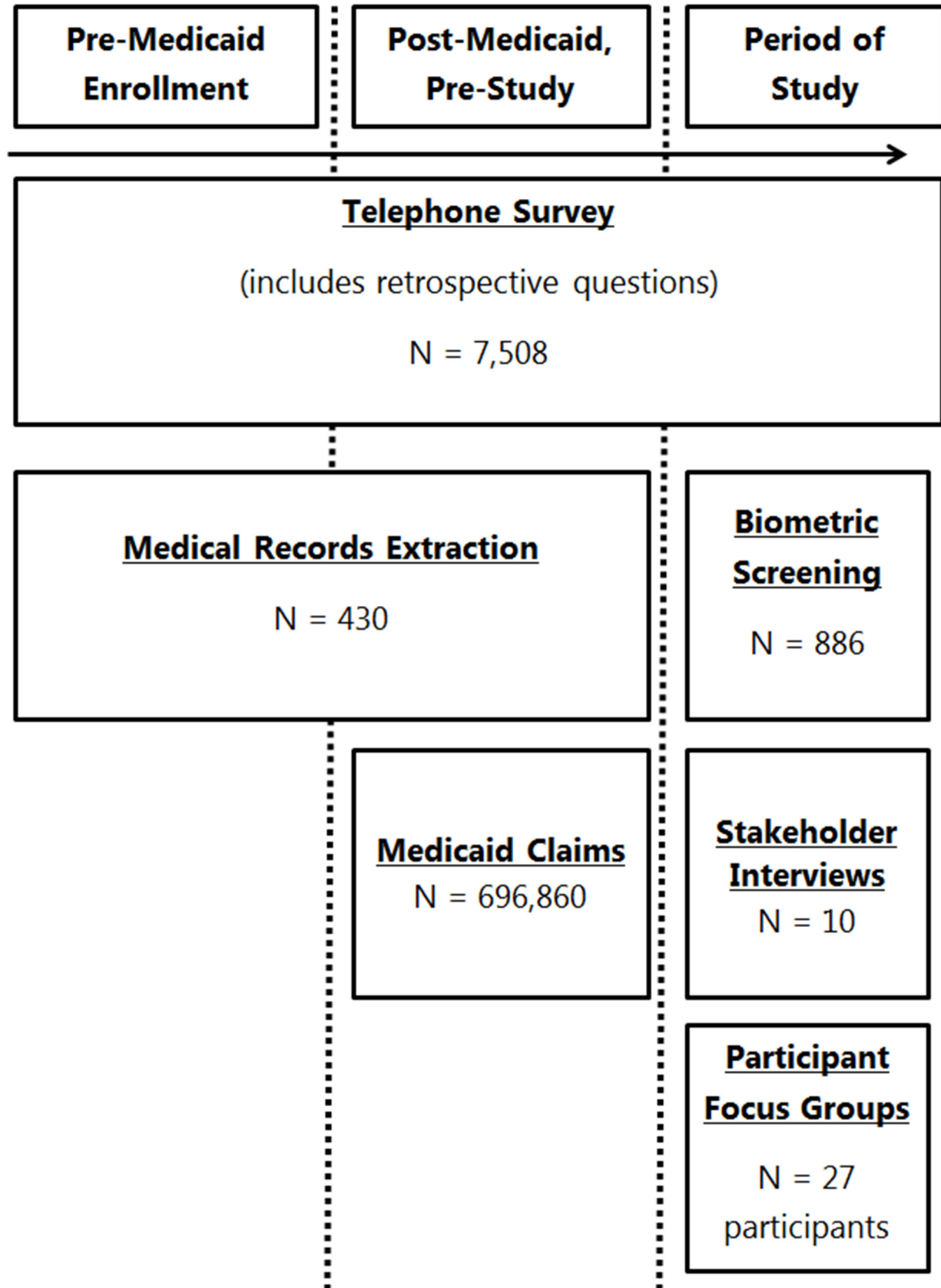
The second study module was a biometric screening of a random selection of Group VIII enrollees who completed the Group VIII Survey. The function of the biometric screening was to supplement the self-reported health status survey data with clinical information. During the biometric screening, permission was requested for researchers to examine medical records.

Medical records collection was the third module and was designed to compare the participant's health diagnoses, conditions, and health system use, pre- and post-Medicaid enrollment. The function of the medical records abstraction module was to identify trends in Group VIII enrollee health system use and health conditions via clinical information.

To serve as a baseline verification of the Ohio Medicaid Group VIII Assessment Survey biometric and medical records abstraction modules, the research team performed a comprehensive study of Ohio Medicaid administrative data for the entire study-eligible universe of Group VIII and pre-expansion Medicaid enrollees using analysis parameters from the Healthcare Effectiveness Data and Information Set (HEDIS) standards. These measurements examined various health conditions, health care system utilization (including preventive care), and rates of evidence-based care for select chronic conditions.

To capture qualitative measures about the value of Group VIII Medicaid enrollment for participants, the last module consisted of group interviews with select Group VIII enrollees and with Medicaid stakeholders, including representatives of provider groups. The questions asked in these interviews addressed topics that were determined to be substantial in the Group VIII Survey and biometric screenings. These interviews were transcribed into text and coded in relation to the prior modules' findings.

Figure 1. Study Design and Data Structure for Group VIII Assessment



Once all data collection was completed, analyses were performed on each independent module and comparatively between modules, when appropriate. These data provide the majority of results contained within the Ohio Medicaid Group VIII Assessment and within the companion Methodology Report. The following subsection descriptions provide more specific details on each of the data sources used for this assessment.

5. Data Sources

The primary data sources for this report include the following:

1. **Telephone Survey:** A total of 7,508 Medicaid enrollees participated in a detailed telephone survey, including 5,111 Group VIII enrollees and 2,397 pre-expansion enrollees. The sample was drawn using a stratified random selection of current Medicaid enrollees from both pre-expansion and Group VIII eligibility groupings, excluding the categories determined to be ineligible for the study (see Methodology Report). The cooperation rate of 76.1% for the telephone survey was stronger than expected, and the response rate of 24.1% is similar to other surveys of low-income populations.^{22,23,24,25,26} The telephone survey included both closed- and open-ended questions. Data from the survey allowed for (a) identification of changes experienced by Group VIII enrollees since enrolling in Medicaid, and (b) comparisons between Group VIII and pre-expansion enrollees.
2. **Biometric Screening:** A random subset of telephone survey respondents from 22 counties were invited to participate in a biometric screening. Respondents met in person with a nurse who checked and recorded their blood pressure, heart rate, cholesterol levels, hemoglobin A1c, height, and weight. These counties, which represent over 70% of Ohio's total Medicaid enrollment, were selected with the goal of obtaining a representative number of biometric screenings in urban, rural, and suburban county types. A total of 886 respondents participated in the biometric screening, including 599 Group VIII enrollees and 287 pre-expansion enrollees. The show rate for respondents who agreed to participate in the biometric screening was 68%, which was expected.^{27,28} The biometric screening allowed for verification and expansion of survey responses.
3. **Medical Records Examination:** Group VIII enrollees who completed the biometric screening were asked to provide voluntary access to their medical records. Approximately 92% of biometric screening participants signed authorization forms to allow access to their medical records from health care providers who served as their usual source of care in 2013 and for the period covering 2015-2016. These enrollees were associated with 430 eligible medical provider groups, 89% of which provided medical records for at least one of their patients for these time periods. Medical records covering the complete time period of pre- and post-expansion were obtained for 174 respondents, as many of the participants were previously uninsured and had no available medical records prior to enrollment in Medicaid. All medical records were reviewed for information on health status, chronic disease diagnoses, preventive screenings, and medical treatments/prescriptions.
4. **Medicaid Claims and Administrative Data:** Medicaid claims data were analyzed for participants who were enrolled in Medicaid for at least 11 months in 2015. This included 219,342 Group VIII enrollees and 477,518 pre-expansion enrollees. Sub-analyses were conducted for those who participated in the telephone survey and biometric screening. Analyses used well-established measures from HEDIS. Review of Medicaid claims enabled confirmation that the telephone survey sample was representative of the broader Medicaid population. In addition, claims data were used to (1) calculate measures of health care utilization, including preventive care and evidence-based care for chronic health conditions; (2) compare the health-related characteristics of Group VIII and pre-expansion enrollees; and (3) analyze changes in health status during the study period.

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5. **Focus Groups and Qualitative Interviews:** Two types of qualitative studies were conducted. First, focus group sessions (with 27 total participants) were held in Cuyahoga, Muskingum/Licking (combined), and Montgomery counties. These sessions were conducted with individuals who participated in one or more of the following: telephone survey, biometric screening, and medical records examination. Second, qualitative interviews were conducted with a total of 10 invited Medicaid program stakeholders, including health care provider associations. These qualitative studies were designed to obtain more in-depth information about survey responses and to examine the perspectives of Medicaid stakeholders on the effects of Medicaid expansion.
 6. **Ohio Medicaid Assessment Survey:** The 2015 Ohio Medicaid Assessment Survey (OMAS) is a telephone survey that samples both landline and cell phones of Ohio residents. The survey examines insurance status, access to the health system, health statuses, demographics and other characteristics of Ohio's Medicaid, Medicaid eligible, and non-Medicaid populations. In 2015, researchers completed 42,876 interviews with adults and 10,122 proxy interviews of children. The 2015 OMAS is the sixth iteration of the survey (previously known as Ohio Family Health Survey). Analyses from the 2015 OMAS addressed baseline information of prior insurance status, unmet health care needs, and family socioeconomic distress for the totality of Ohio and the Medicaid population from a population health point of view. For details, please see the 2015 OMAS Methodology Report.²⁹

More detail on all of these data collection methods is given in the Methodology Report accompanying this report.

6. Group VIII Assessment Sections

Responding to the statutory mandate, this report examines the impact of Medicaid expansion on Group VIII enrollees as follows:

- Access to and utilization of health care (Section III)
- Changes in physical health, with a focus on chronic disease diagnoses and risk factors (Section IV)
- Changes in mental and behavioral health (Section V)
- Financial well-being and employment (Section VI)

Although long-term changes in health cannot yet be assessed, to date Medicaid expansion has been strongly beneficial to Group VIII enrollees in all of these areas. This conclusion is confirmed by the multiple data sources used to prepare this assessment.

II. Population Characteristics of Group VIII Enrollees

This section presents information about the population that has enrolled in Ohio Medicaid through Group VIII eligibility. Medicaid expansion has produced a significant increase in health care coverage—and a corresponding decrease in Ohio’s uninsured rate—as the majority of Group VIII enrollees were previously uninsured.

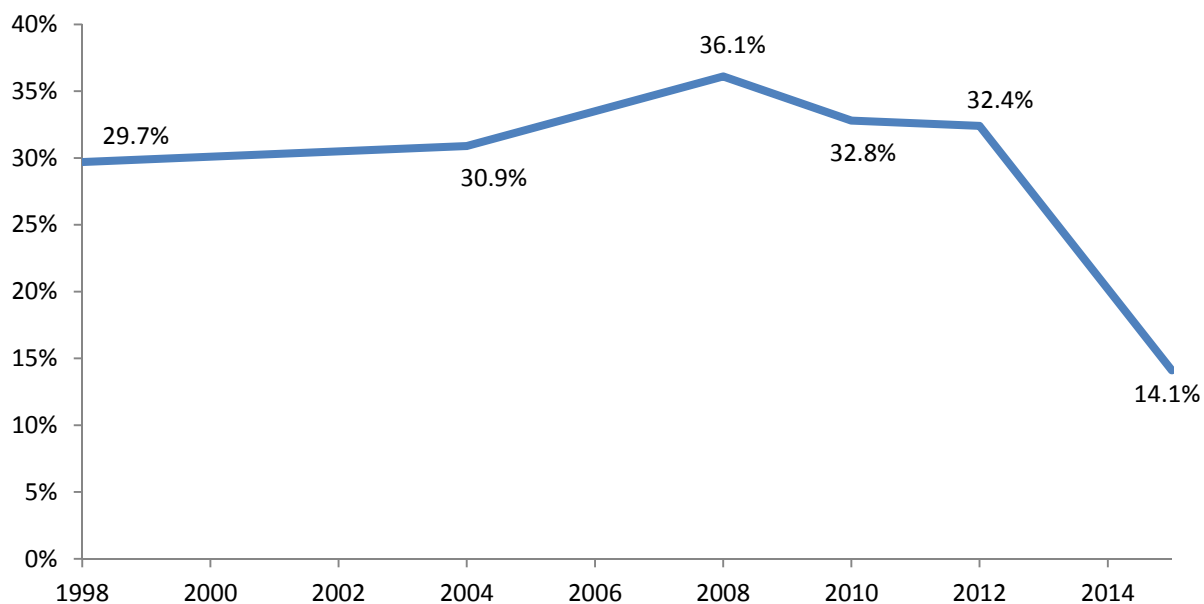
Group VIII enrollees demonstrated high levels of both physical and mental health needs, which the Medicaid program is helping them to address. Because of demographic differences (age, sex, and race), Group VIII enrollees had slightly higher rates of chronic diseases, particularly cardiovascular disease, than pre-expansion enrollees. In particular, males 45-64 years of age had elevated rates of physical health conditions compared to other enrollees.

1. Insurance Characteristics

As of May 2016, more than 702,000^v Ohioans were enrolled in Medicaid through the Group VIII expansion. In part, resulting from Medicaid expansion, Ohio recorded its lowest adult uninsured rate ever in 2015, at 8.7% for all adults 19-64 years of age. In 2012, the adult uninsured rate was 17.3% (OMAS).

The decline in the uninsured rate was particularly notable for low-income Ohioans. For adults with family incomes under 138% of the FPL, the uninsured rate declined from 32.4% in 2012 to 14.1% in 2015 (Figure 2), the lowest rate ever recorded (OMAS). This precipitous decline was almost entirely the result of Medicaid expansion.

Figure 2. Percentage of Ohioans age 19-64 With Family Income at or Below 138% of the Federal Poverty Level Without Insurance From 1998 to 2015



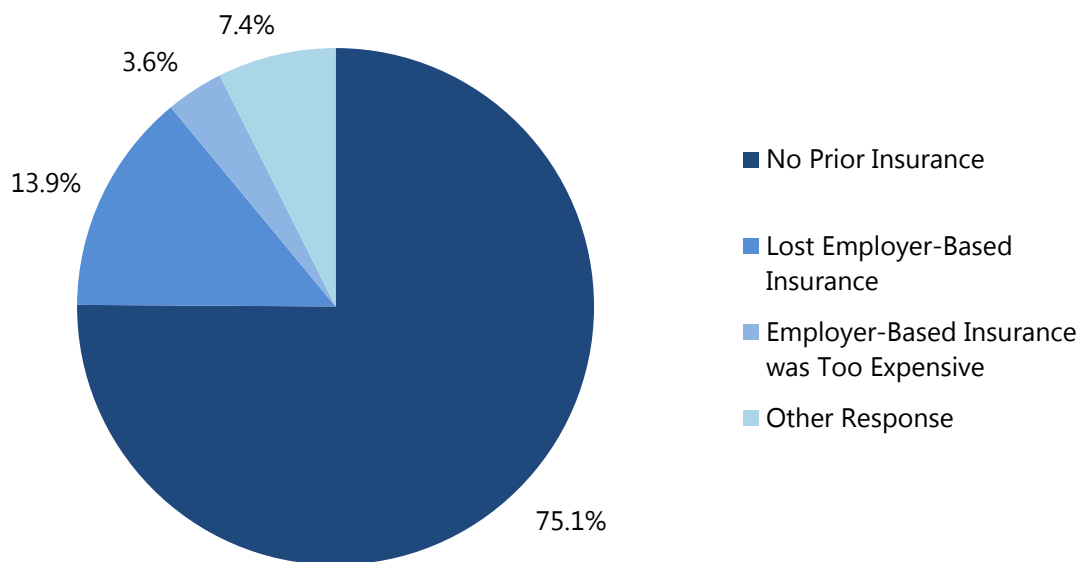
Source: Ohio Medicaid Assessment Survey.

A question regarding Medicaid expansion is whether it attracted people who were currently uninsured or brought people who were otherwise covered into public insurance. According to the Group VIII Survey, 89.0% of Group VIII enrollees were uninsured just prior to Medicaid expansion, including 75.1% who had no prior insurance and 13.9% who had recently lost their employer-based coverage (Figure 3). The remaining 11.0% had some other form of coverage, with 3.6% stating that their employer-based insurance was too expensive to keep (the

^v This number is unpublished and includes retroactive and backdated enrollments for May processed through November. The source for the estimate is ODM. See the Methodology Report for details regarding enrollment calculations.

insurance substitution rate). Looking specifically at the 24.9% of Group VIII enrollees who had prior insurance within the year before enrollment, 55.8% transitioned to Medicaid because they lost employer-sponsored insurance, and an additional 14.5% transitioned to Medicaid because their employer-sponsored insurance was too expensive.^{30,31} These numbers are similar to trends for pre-expansion enrollees over the past decade.

Figure 3. Insurance Status Prior to Enrollment Among Group VIII Enrollees and Reasons for Enrolling in Medicaid Expansion



Source: Group VIII Telephone Survey.

2. Demographic Characteristics

Compared to pre-expansion enrollees, Group VIII enrollees who completed the telephone survey were more likely to be unmarried, male, older (45-64 years), and without children in the household (Table 1). The racial/ethnic background and educational attainment of Group VIII and pre-expansion enrollees were similar, although Group VIII enrollees were somewhat more likely to be white, to have college degrees, and to be employed. These demographic differences are largely the result of the different eligibility criteria for Group VIII enrollment compared to pre-expansion eligibility criteria. Before the 2014 expansion, the largest group of adults enrolled in Ohio Medicaid was women with children in the household (Ohio Medicaid Data, Ohio Medicaid Assessment Survey).

Table 1. Demographic Characteristics of Group VIII Enrollees and Pre-Expansion Enrollees

	Group VIII		Pre-Expansion	
	Weighted Average	Unweighted N	Weighted Average	Unweighted N
Male	55.8%	2,502	30.2%	762
Age				
19-44 years	49.6%	1,992	76.3%	1,484
45-64 years	50.4%	3,119	23.7%	913
Race				
White	71.5%	3,944	67.5%	1,759
Black	24.8%	997	28.0%	541
Other	3.7%	170	4.5%	97
Ethnicity				
Hispanic	3.6%	159	5.0%	104
Education				
High School or Less	58.1%	3,031	62.2%	1,512
Some College	28.3%	1,431	30.4%	704
4-Year Degree or More	13.1%	628	6.8%	167
Marital Status				
Married	15.6%	875	26.8%	648
Divorced	26.0%	1,518	24.4%	692
Widowed	3.8%	247	2.1%	60
Never Married	48.3%	2,174	39.9%	842
Domestic Partner	5.7%	266	6.2%	138
Children in the Household	17.9%	836	75.4%	1,688
Currently Employed	43.2%	2,138	41.5%	921

Source: Group VIII Telephone Survey.

3. Physical and Mental Health Characteristics

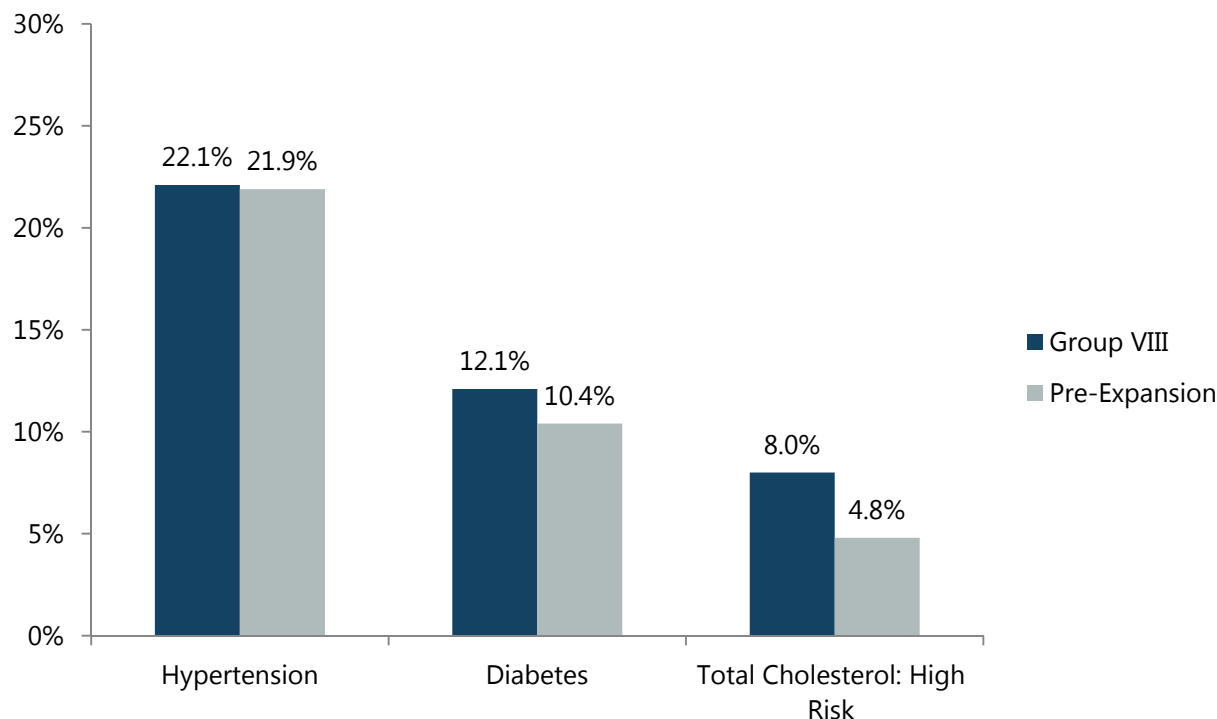
Because the Group VIII enrollees are, on average, older and more likely to be male than pre-expansion enrollees, they face some different health challenges. For example, among those who participated in the biometric screening, members of the Group VIII population were more likely to have at-risk levels of blood pressure, hemoglobin A1c (blood sugar) levels consistent with diabetes, and high cholesterol than pre-expansion enrollees (Figure 4). However, these differences were primarily the result of differences in demographic characteristics. In a series of statistical models with demographic controls, differences between pre-expansion and Group VIII enrollees in terms of hypertension (high blood pressure), blood sugar levels, and cholesterol were not statistically significant (appendix Figure 4). The detailed results from these statistical models are available in the Methodology Report.^{vi}

Using the biometric data, Group VIII enrollees were identified as having higher levels of cardiovascular risk than pre-expansion enrollees. This was based on a validated risk score that combined a number of factors (detailed in the Methodology Report) to estimate the likelihood of developing cardiovascular disease. The higher

^{vi} Note that the biometric screenings measured markers of health at a single point in time. These results cannot be used to make assumptions or comparisons about the health of these populations at any earlier points in time. Additionally, the biometric screening does not identify people who may have had health risk markers in the past but who have received effective treatment.

cardiovascular risk for the Group VIII population was expected, given that age and sex are two important factors in determining cardiovascular risk, and the Group VIII population is older with a higher proportion of males.

Figure 4. Prevalence of Health Risk Markers



Individuals with the above diseases who were treated to levels below diagnostic levels are not accounted for in this analysis. More information on the risk level definitions is available in the Methodology Report. Source: Group VIII Biometric Screening.

Key Findings

Medicaid expansion resulted in new health insurance coverage for 702,000 Ohioans in May 2016, the vast majority of whom were previously uninsured.

In comparison to pre-expansion enrollees, Group VIII enrollees are more likely to be male, older (45-64 years), and without children.

As a result of demographic differences, Group VIII enrollees had higher rates of cardiovascular risk factors such as hypertension and high cholesterol than pre-expansion enrollees.

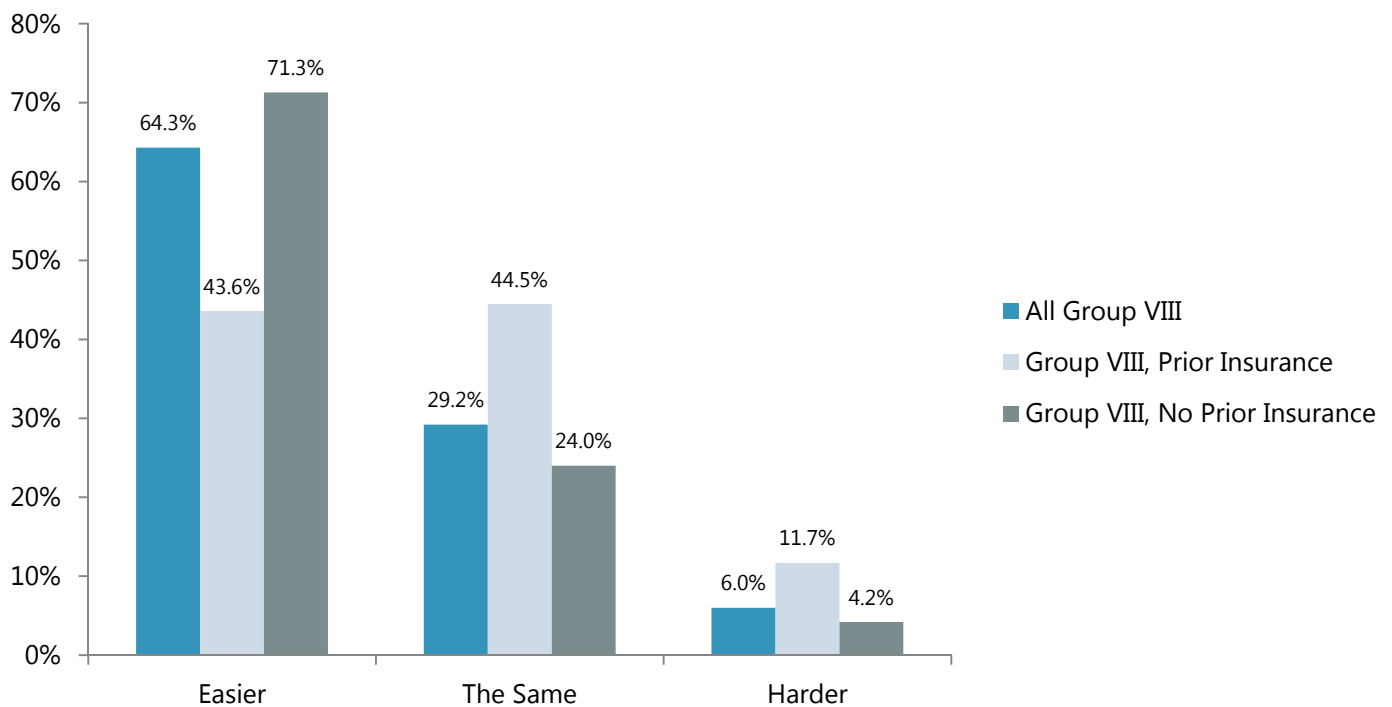
Studies from other states that have expanded Medicaid have similarly found large increases in Medicaid enrollment, primarily because of the enrollment of adults who were previously uninsured.¹

III. Health System Access and Utilization

A key goal of providing health care coverage is for people to better integrate into the health care system. Past reports show that the uninsured are less likely to have a usual source of care and more likely to use of the ED as a usual source of care. Additionally, the uninsured demonstrate lower utilization of preventive care and higher levels of unmet health needs.^{32,33,34,35} This combination of experiences creates a lack of continuity to care and delays in seeking needed care that can often result in later diagnosis of health conditions, use of higher cost sources of care, lower levels of appropriate care being received, and poorer overall health outcomes.

Group VIII enrollees overwhelmingly reported that access to medical care has become easier since enrolling in Medicaid (Figure 5), which has reduced their unmet medical needs. Enrollment in Medicaid has enabled Group VIII enrollees to obtain a usual and appropriate source of care that, in turn, has likely contributed to decreased use of ED care and better management of chronic health conditions.

Figure 5. Changes in Ease of Access to Care Since Enrolling in Medicaid



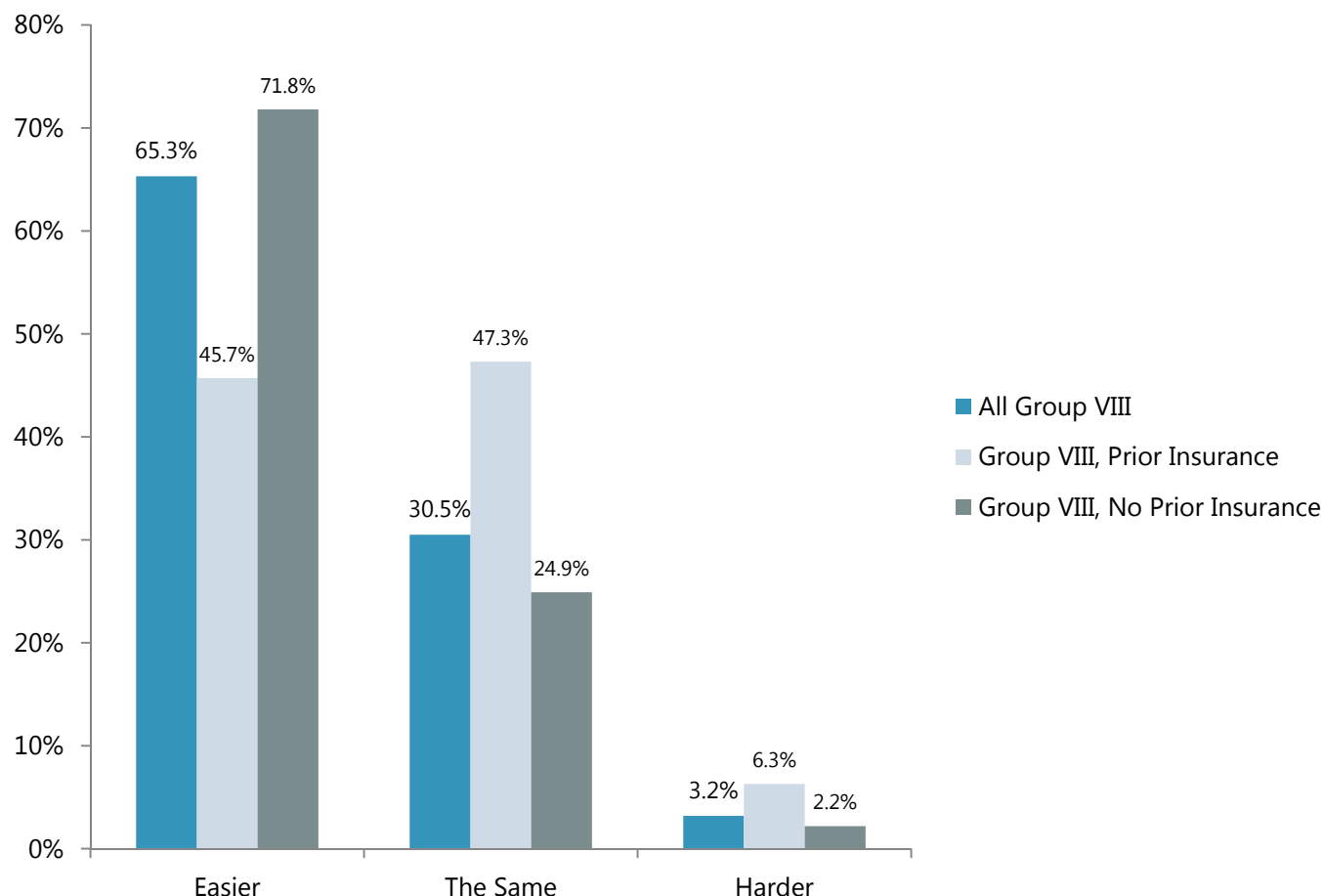
Source: Group VIII Telephone Survey.

1. Access to Care

A majority of Group VIII enrollees reported improved access to care since enrolling in Medicaid; 64.3% stated that accessing care had become easier, 6.0% stated that it had become harder, and 29.2% stated that ease of access remained the same. Getting care became easier for a substantial percentage of Group VIII enrollees with prior insurance (43.6%), indicating that improved access to care was not limited to Group VIII enrollees who were previously uninsured.

Large percentages of Group VIII enrollees reported better access to a variety of health services, including dental care, vision care, and mental health services. Two-thirds of Group VIII enrollees (65.3%) stated that filling prescriptions had become easier, and only 3.2% reported that filling prescriptions had become more difficult (Figure 6).

Figure 6. Changes in Ease of Filling Prescriptions Since Enrolling in Medicaid



Source: Group VIII Telephone Survey.

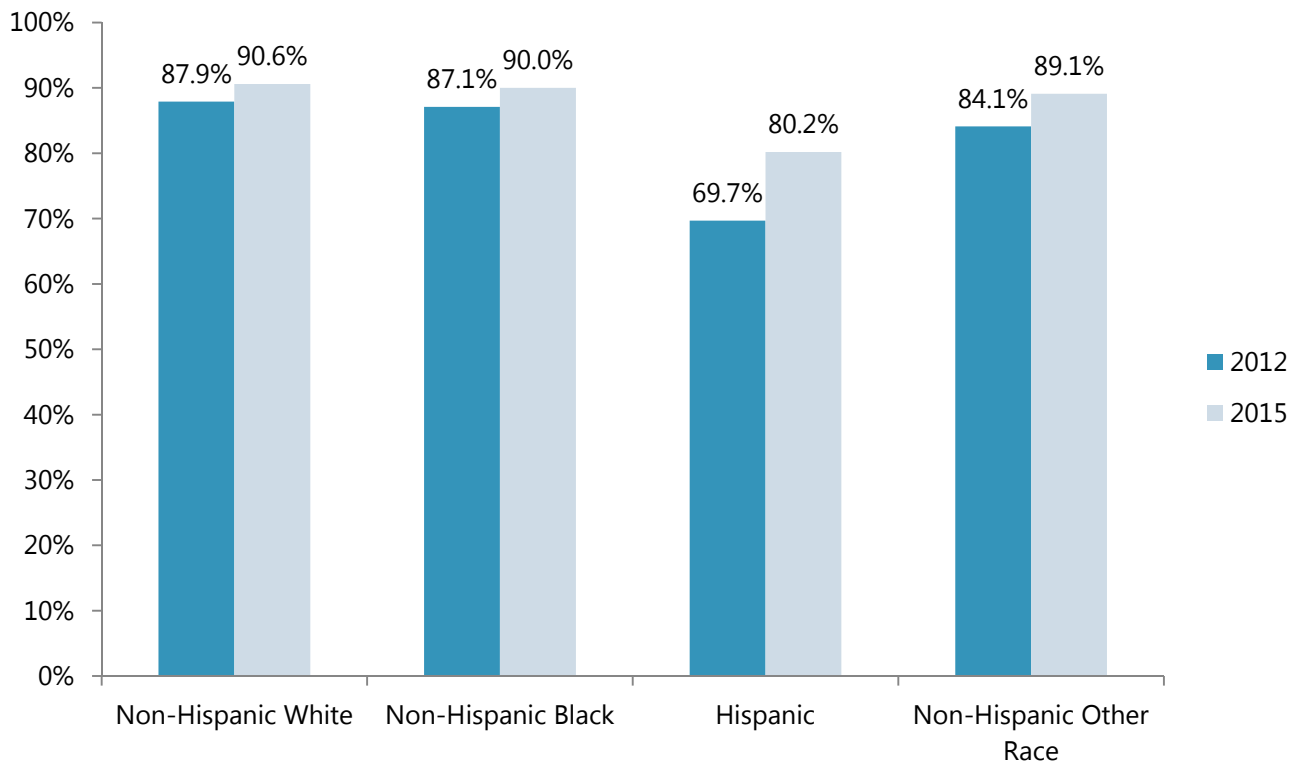
2. Usual Source of Care

A usual source of health care is defined as a particular medical professional or health center where a person would usually go when in need of health care advice or health care services. The main reasons for not having a usual source of care besides seldom getting sick are prohibitive cost for securing health care, being uninsured, and a lack of knowledge concerning when and how to secure health care services.³⁶ A significant percentage of Group VIII enrollees (32.2%) reported that before they obtained Medicaid coverage they did not have a usual health care provider. This included 21.0% of enrollees with prior insurance and 36.0% of enrollees who were previously uninsured.

For Group VIII enrollees who did not have a usual source of care prior to enrolling in Medicaid, a majority (58.4%) reported having a usual source of care (other than emergency department) at the time they were surveyed. Even among Group VIII enrollees with prior insurance and no usual source of care prior to enrolling in Medicaid, a majority (51.8%) reported having a usual source of care at the time of the study.

Additionally, Medicaid expansion has narrowed the racial and ethnic disparities in access to usual sources of care. Among low-income Ohioans ($\leq 138\%$ FPL), those identifying as Hispanic showed the largest percentage increase in connecting to a usual source of care between 2012 and 2015. However, the percentage of low-income Hispanic Ohioans with a usual source of care (80.2%) still lags behind the comparable percentage for low-income White (90.6%) and Black (90.0%) Ohioans (Figure 7).

Figure 7. Percentage of Ohioans With Income at or Below 138% FPL With a Usual Source of Care by Race, 2012-2015



Source: Ohio Medicaid Assessment Survey.

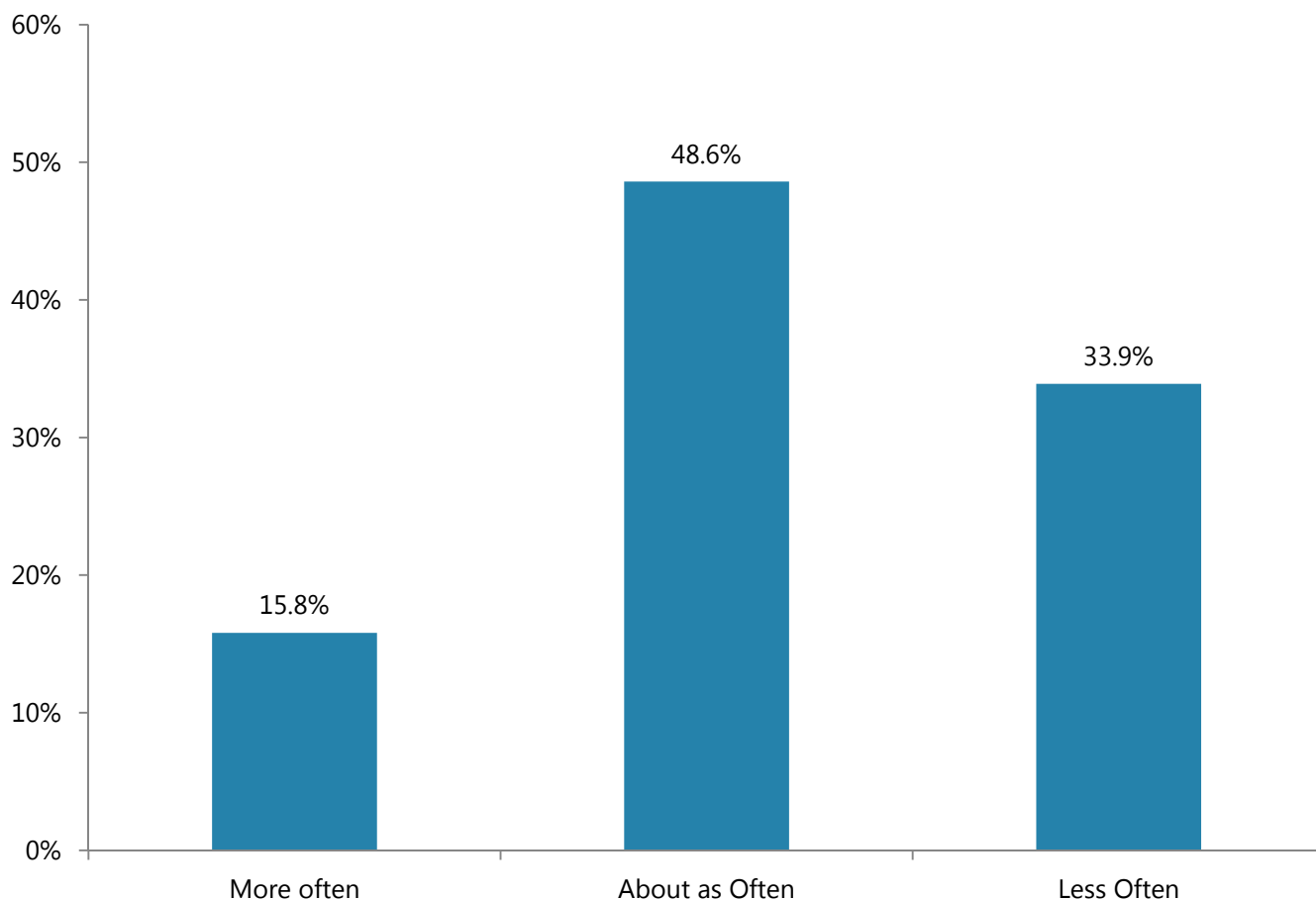
A review of the medical records for Group VIII enrollees with visits to their usual source of care both prior and subsequent to the Medicaid expansions revealed an increase in the likelihood of having two or more visits in a given year since enrollment. This finding supports the telephone survey results that Group VIII enrollees are accessing needed preventive and primary health care.

The medical records review was carried out for a total of 430 Group VIII enrollees. Of these enrollees, 301 reported in the biometric screening having the same usual source of care in 2013, before expansion, as in 2015–2016, after expansion. Of these 301 Group VIII enrollees, 174 medical records were obtained and abstracted for both time periods (pre- and post-expansion). The two main reasons for this were: (1) there being no observable visits on the medical records with their usual source of care in 2013; and (2) health care provider nonresponse. For the subset of Group VIII enrollees with abstracted medical records who identified the same specific provider (as opposed to a group practice) for both time periods, it was determined that a minority sought care with their usual source of care provider during the post-expansion period. These results are indicative of a substantial increase in access to care for Group VIII enrollees—most of who were uninsured and indicated no change in their usual source of care between 2013 and 2016.

3. Emergency Department Use

After Medicaid expansion, emergency department (ED) use tended to decline among Group VIII enrollees. About a third of Group VIII enrollees (33.9%) reported fewer trips to an ED since enrollment, while 15.8% reported an increase and 48.6% reported that use remained the same (Figure 8). The decline in utilization rates was similar for Group VIII enrollees with and without prior insurance.

Figure 8. Changes in Frequency of Emergency Department Use Since Enrolling in Medicaid



Source: Group VIII Telephone Survey.

Medicaid claims data also demonstrated that Group VIII enrollees were less likely than pre-expansion enrollees to visit the ED. When they did visit an ED, it was more likely to be for a medical condition typically best treated in the ED, such as myocardial infarction (heart attack), acute respiratory failure, or a traumatic brain injury. In particular, Group VIII enrollees aged 45-64 had substantially fewer visits to the ED than pre-expansion enrollees in the same age range (Figure 9). Additional analyses of Medicaid claims revealed that Group VIII enrollees were less likely to use an ED than pre-expansion enrollees for visits in which no immediate care was needed (23.1% versus 26.3% of total visits) and for which care was needed but could have been provided by a primary care provider (21.7% versus 23.0%). Because the ED is an expensive setting in which to deliver care, reducing ED visits for non-emergent care has the potential to lower overall health care costs for the Group VIII population.³⁷

When asked what getting Medicaid meant to them, 31.3% of respondents specifically mentioned improved access to care, with many mentioning reduced use of the ED.

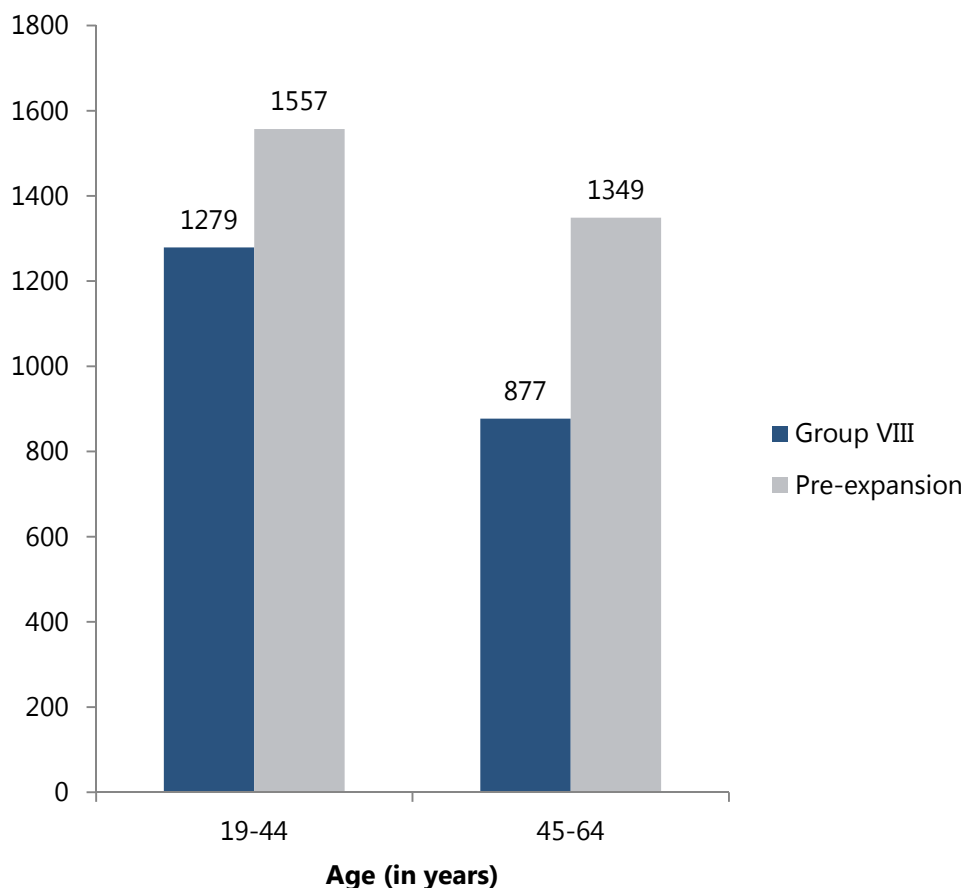
"I'm happy that I can make appointments without going to the emergency room."

"It brought some comfort to know if I was to get sick I can go to a hospital and get treatment and not have to get emergency room care."

"It has helped me a lot. When I didn't have Medicaid I wouldn't go to doctor or hospital. I would use the hospital emergency room as a clinic."

Source: Group VIII Telephone Survey.

Figure 9. Number of Emergency Department Visits per 1,000 Member-Years in 2015



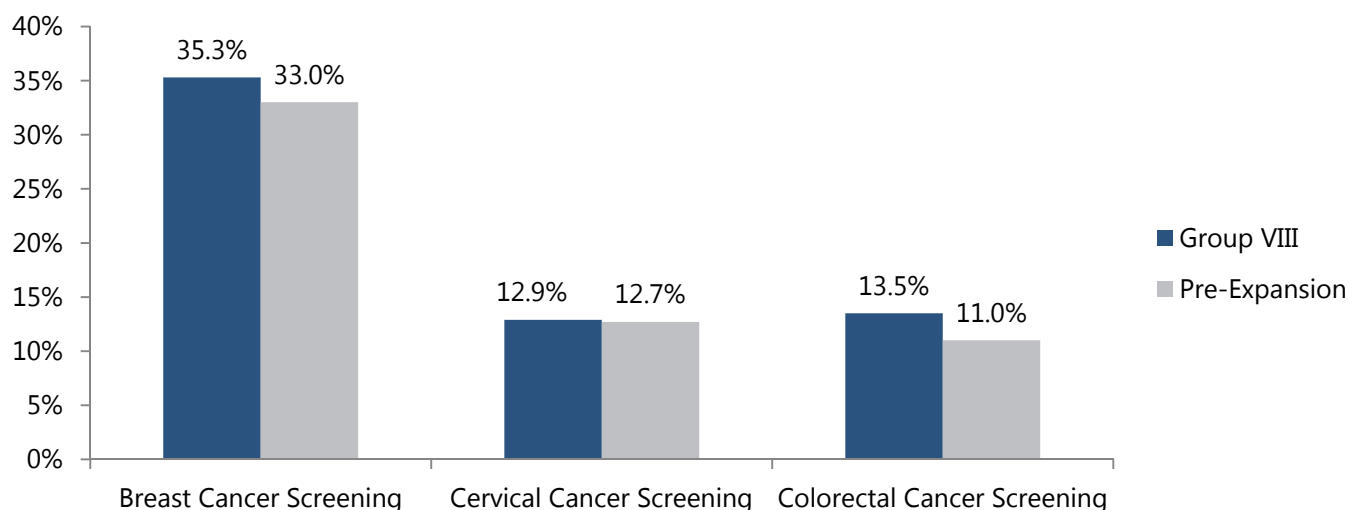
Source: Medicaid Administrative Data.

4. Access to Preventive Care

Medicaid expansion was, in part, intended to facilitate access to preventive services that could help avoid the onset of costly and debilitating diseases. Decades of research suggest that evidence-based clinical preventive services are cost-effective and can be cost-saving.³⁸

Medicaid claims data suggest that Group VIII enrollees are obtaining clinical preventive services at rates comparable to those of pre-expansion enrollees (Figure 10). For example, in 2015, 35.3% of Group VIII female enrollees over the age of 50 obtained breast cancer screenings, compared to 33.0% of pre-expansion enrollees. These data are limited to Group VIII enrollees and pre-expansion enrollees who were eligible for these screening procedures.

Figure 10. Percentage of Group VIII and Pre-Expansion Enrollees Who Qualified for and Received Health Screenings in 2015^{vii}



Source: Medicaid Administrative Data.

5. Appropriate Care for Chronic Conditions

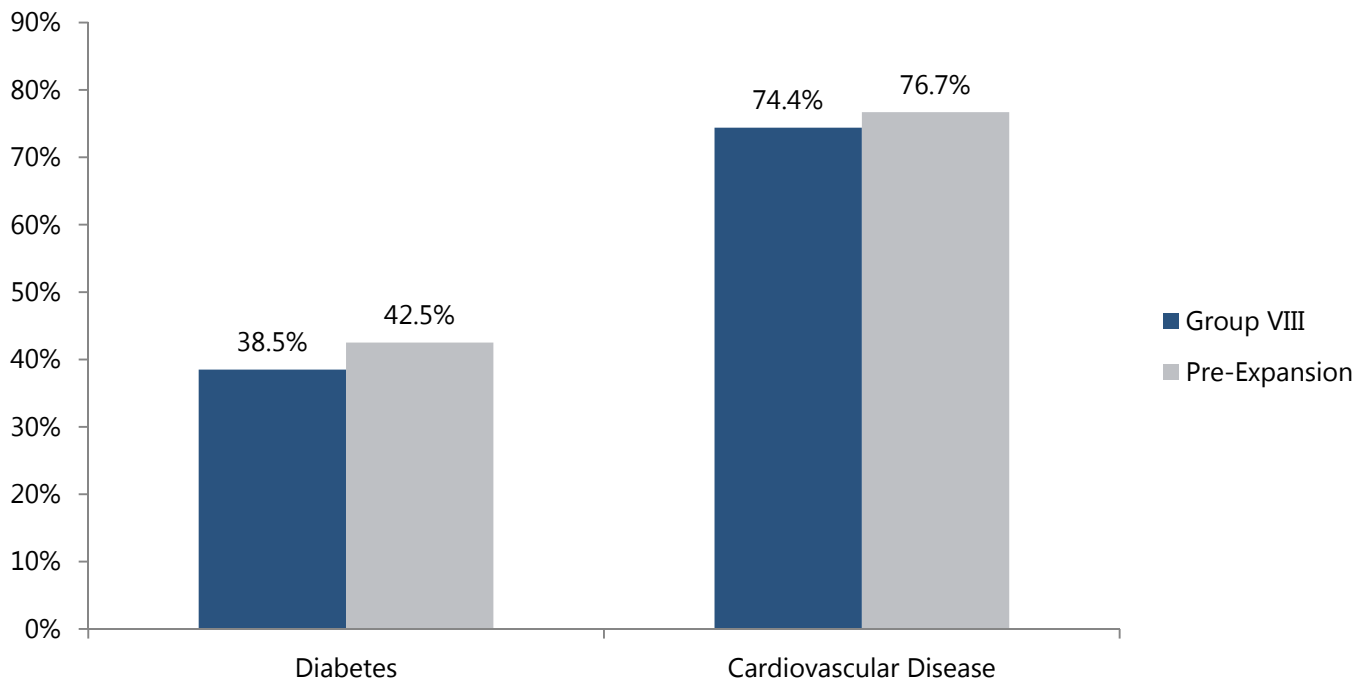
An important function of primary care providers is the treatment of chronic conditions. According to Medicaid administrative data, a large percentage of Group VIII enrollees with chronic condition diagnoses were receiving appropriate care from a clinician based on evidence-based clinical guidelines.

For patients with Type 2 diabetes or cardiovascular disease, statin therapy is a widely used evidence-based treatment.^{39,40} Similar percentages of Group VIII enrollees and pre-expansion enrollees with diabetes received statin therapy (38.5% versus 42.5%); likewise, the percentage of patients with cardiovascular disease receiving statins was comparable (74.4% of Group VIII enrollees versus 76.7% of pre-expansion enrollees) (Figure 11). (Statin use for treatment of cardiovascular disease in both the Group VIII and pre-expansion populations exceeded the U.S. average of 58.1% in 2013.⁴¹)

Analyses of Medicaid administrative data indicated that a large majority of Group VIII enrollees with hypertension also had well-controlled blood pressure. Because the care experience and treatment regimens for patients with hypertension and diabetes and those with hypertension but without diabetes are different, the results for these two groups are reported separately. Among Group VIII enrollees with hypertension and diabetes, 79.6% had well-controlled blood pressure, compared to 80.5% for pre-expansion enrollees (Figure 12). Hypertensive Group VIII enrollees without diabetes were less likely to have well-controlled blood pressure (68.1%, compared to 70.6% for pre-expansion enrollees). These results exceed the Healthy People 2020 objective of 61.2%.⁴²

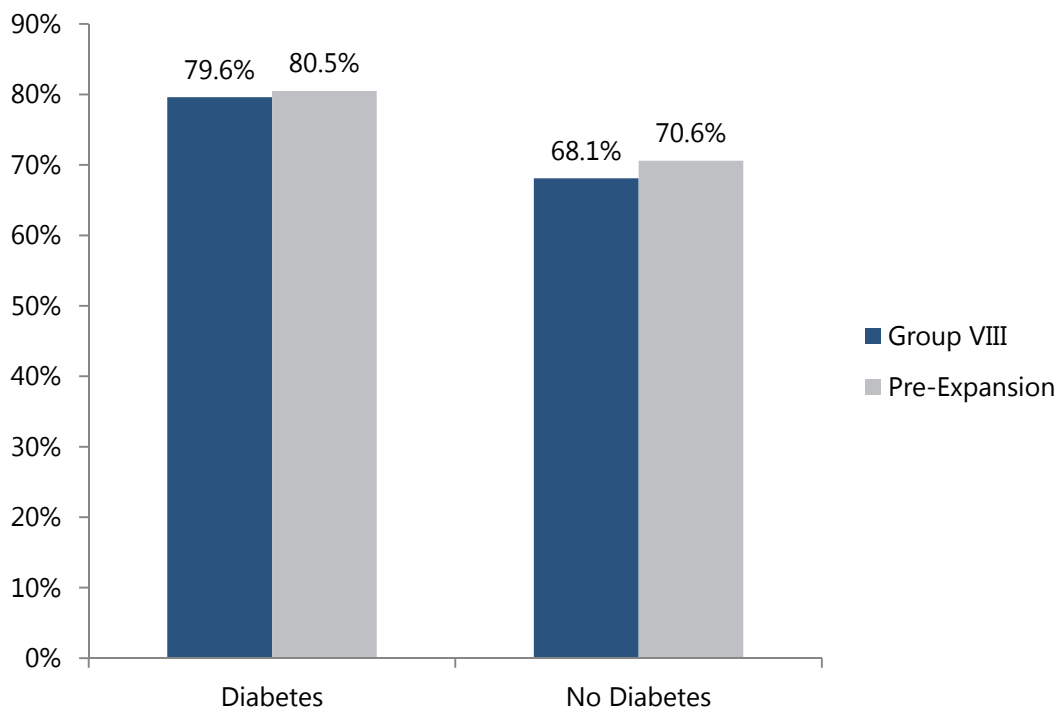
^{vii} Not all screenings are performed annually. According to the United States Preventive Services Task Force, the recommended period between screenings is every other year for breast cancer screening (mammography) at age 50, 3 to 5 years for cervical cancer, and yearly to every 10 years for colorectal cancer depending on screening modality, starting at age 50.

Figure 11. Percentage of Group VIII and Pre-Expansion Enrollees With Diabetes or Cardiovascular Disease Diagnoses Who Received Statin Therapy



Source: Medicaid Administrative Data.

Figure 12. Percentage of Group VIII and Pre-Expansion Enrollees With Hypertension Diagnoses Who Have Well-Controlled Blood Pressure by Diabetes Status



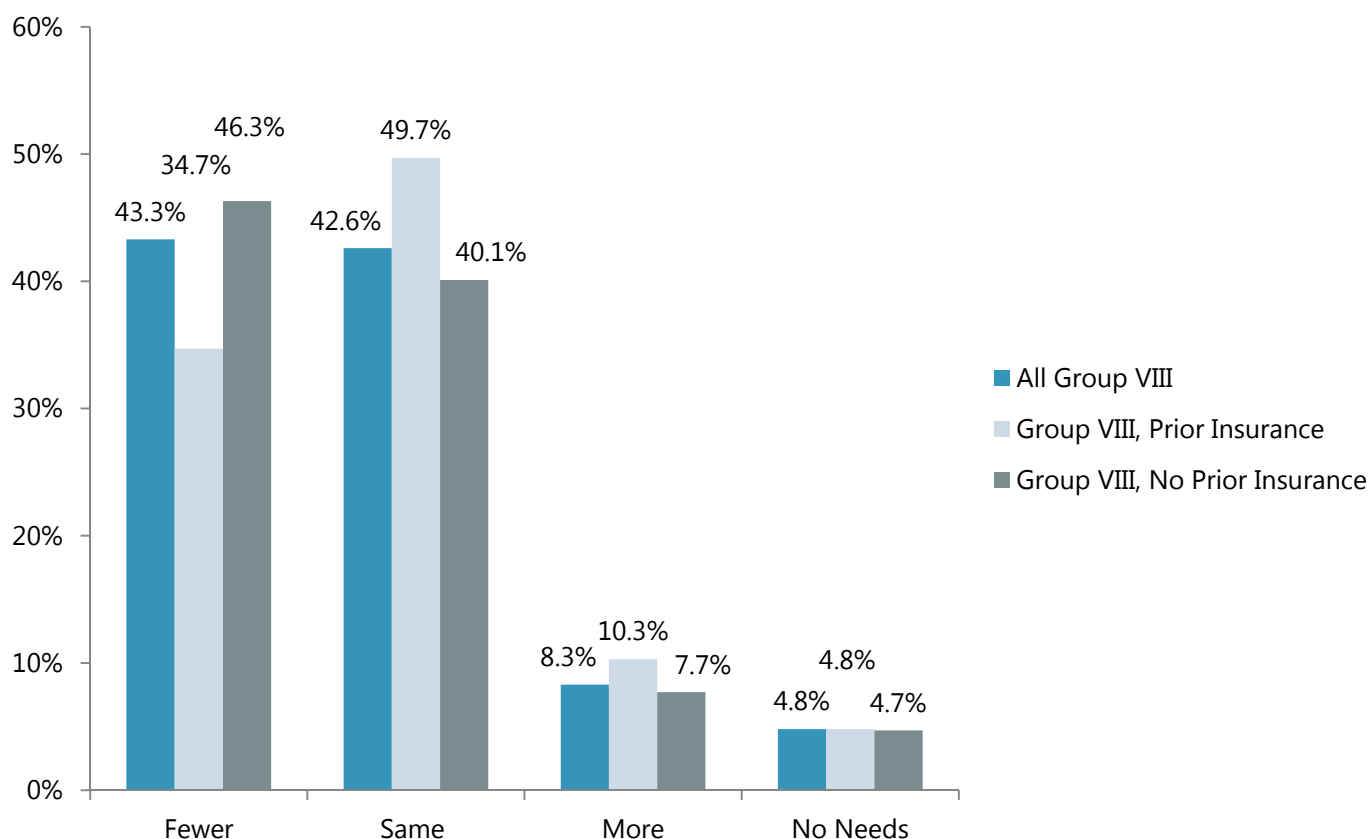
Source: Medicaid Administrative Data.

6. Unmet Health Care Needs

An unmet health care need indicates a physical or mental health condition that is not being addressed. Causes of unmet needs can be classified as barriers to availability, accessibility, and acceptability of services. Problems of *availability* include too-lengthy wait times, services not available when required, and services not available in a geographic area. Problems of *accessibility* include reasons related to cost and transportation. Problems of *acceptability* of available service usually relate to personal preferences or individual circumstances. Unmet needs were examined in the Ohio Medicaid Group VIII Survey for general health, dental health, and mental health.

Overall, Group VIII enrollees reported widespread declines in unmet health care needs (Figure 13). Forty-three percent of Group VIII enrollees reported fewer unmet needs, compared to 8.3% who reported greater needs. Reductions in unmet health care needs were detected for both those who had insurance and those who were uninsured prior to G-VIII enrollment.

Figure 13. Percentage of Group VIII Enrollees Who Have Fewer, More, or the Same Level of Unmet Health Care Needs Since Enrolling in Medicaid



Source: Group VIII Telephone Survey.

Results from the 2015 OMAS indicate that 37.7% of Group VIII enrollees reported general unmet health care needs, 21.0% reported unmet dental needs, 15.0% reported unmet vision needs, 6.9% reported unmet mental health care needs, and 11.2% reported unmet health care supplies needs.

Key Findings

Nearly two-thirds of Group VIII enrollees (64.3%) reported that Medicaid improved their access to general health care. Similar improvements were reported for access to care in the areas of pharmacy, vision, and dental.

Medicaid has enabled most new enrollees who previously lacked a usual source of care to obtain one.

Access to care through Medicaid has reduced unmet medical needs and likely contributed to many individuals reporting less ED use.

These results are consistent with research from other states demonstrating that Medicaid expansion has resulted in improved access to care and medications, increased likelihood of having a usual source of care, and reduced unmet needs. Previous studies have reached inconsistent results about whether Medicaid expansion increases or decreases ED use.¹ The findings from this study suggest that Ohio Medicaid expansion has, on balance, reduced ED use by Group VIII Medicaid enrollees.

IV. Changes in Physical Health

Better integration into the health care system should result in better physical health. However, measuring physical health improvement in the short run is challenging. Although Medicaid expansion is in its third year, this assessment focuses on people who had received coverage for between 12 and 24 months at the time they were studied.

This assessment was able to examine numerous sources that suggest possible impacts on the physical health of Group VIII enrollees. First, survey data were used to determine how many new enrollees were diagnosed with previously undetected chronic health conditions. Preferably, these diagnoses would occur at earlier stages of the disease, soon after enrollees had obtained Medicaid coverage, which has been Ohio Medicaid's experience with those on pre-expansion Medicaid. Second, survey data were combined with Medicaid administrative data and medical records from a subset of participants to examine whether Group VIII enrollees were better able to manage their chronic health conditions. Effective management of chronic conditions is vital to Medicaid given that enrollees with chronic conditions account for 70% to 80% of total Medicaid spending. Finally, individual self-reports of changes in health status served as an additional measure for assessing Medicaid expansion's impact on health.

Because of the short amount of time that has transpired since Medicaid expansion, dramatic improvements in physical health among Group VIII enrollees were not expected. Since enrollment, Group VIII enrollees have (1) been connected to usual health care (as discussed in Section III); (2) obtained diagnoses for preexisting chronic conditions; and (3) accessed appropriate health care for the treatment and management of those conditions.

"[Medicaid is] a life saver. It's got my blood pressure back down to almost normal. I'm just grateful for the coverage because I wouldn't get this care without it because I know it isn't cheap."

"I can go to the doctor for my bronchitis and asthma and can get care. I'm able to be healthier and be more functional at work and able not to miss work because I can get health care that I can afford."

"It means that I am healthier, I have asthma and before I couldn't afford my inhaler. It's been a lifesaver."

Source: Group VIII Telephone Survey.

1. Chronic Disease Diagnoses

When assessing health status, data collection for this assessment focused on issues relating to key chronic diseases. The analyses of the Group VIII enrollees showed that selected chronic disease diagnoses are prevalent in this population. The costs associated with chronic disease treatment are a source of tremendous financial disruption and family stress. They have significant impacts on morbidity and mortality for Medicaid recipients and represent many of the leading causes of death.

Many Group VIII enrollees (38.8%) reported having been diagnosed with at least one chronic condition prior to obtaining Medicaid coverage, indicating that many in the Group VIII population had serious preexisting health needs. Since enrolling in Medicaid, more than one-quarter of Group VIII enrollees (27.0%) have been newly diagnosed with at least one chronic condition (Group VIII Telephone Survey). The most common new diagnoses are shown in Figure 14. A review of medical records of Group VIII enrollees who visited their usual source of care

in both 2013 and 2015-2016 also identified increases in chronic disease diagnoses. For example, more than twice as many Group VIII enrollees who participated in the medical records case study were diagnosed as having diabetes in 2016 compared to 2013 (21%, up from 10%), and the percentage diagnosed with depression increased from 13% to 22%.

These new diagnoses make it difficult to assess changes in health status for Group VIII enrollees before and after Medicaid enrollment. The new diagnoses could superficially—and incorrectly—be read to suggest that some Group VIII enrollees have experienced worsened health since enrolling on Medicaid. It is far more likely, however, that these new diagnoses represent conditions that were previously undiagnosed. Thus, enrollment in Medicaid has enabled enrollees to better understand their current health status and to seek treatment for existing—and potentially life-threatening—risk factors and chronic diseases.

Enrollment in Medicaid was instrumental in both identifying previously undiagnosed health conditions and increasing the likelihood of appropriate care for such conditions. In response to the question about what getting Medicaid has meant to respondents, some mentioned having a better understanding of their health or a health condition.

When asked what getting Medicaid meant to them, 31.3% of respondents specifically mentioned improved access to care, with many mentioning reduced use of the emergency department.

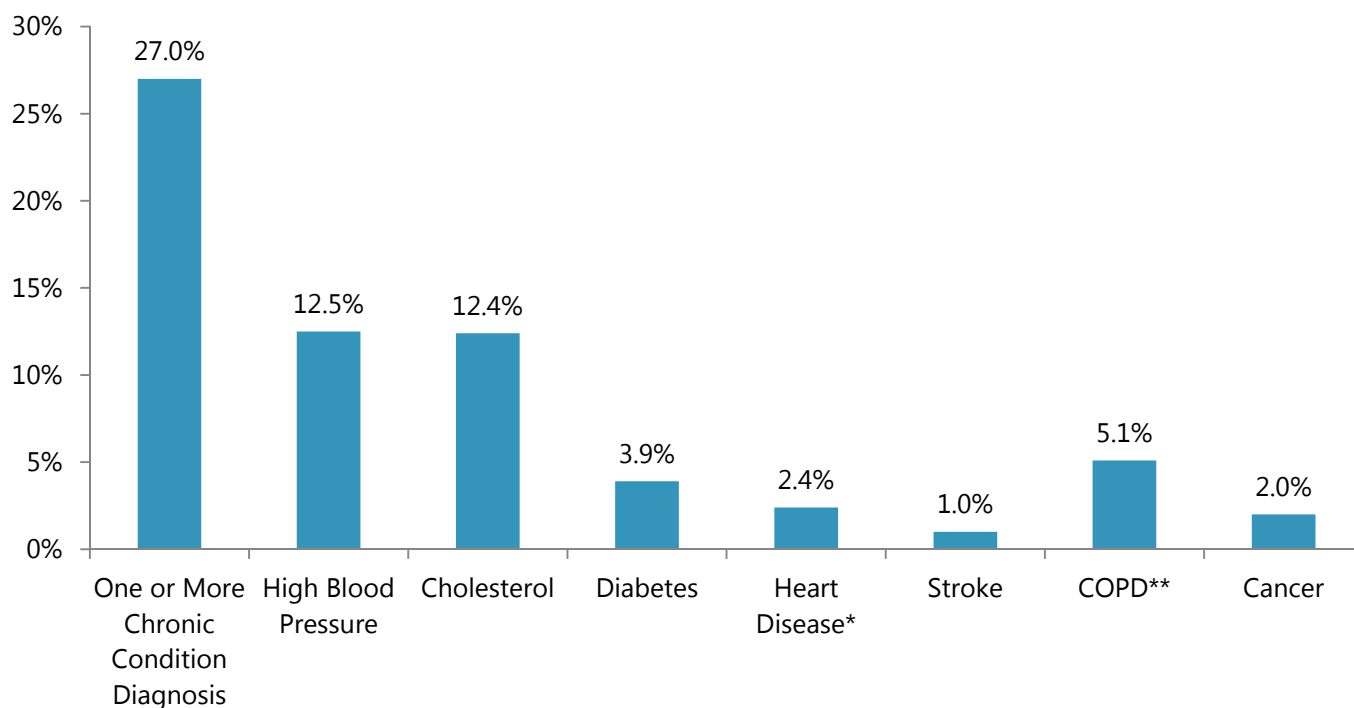
"I'm happy that I can make appointments without going to the emergency room."

"It brought some comfort to know if I was to get sick I can go to a hospital and get treatment and not have to get emergency room care."

"It has helped me a lot. When I didn't have Medicaid I wouldn't go to doctor or hospital. I would use the hospital emergency room as a clinic."

Source: Group VIII Telephone Survey.

Figure 14. Percentage of Group VIII Enrollees Who Reported Receiving a Chronic Condition Diagnosis Since Enrollment



*Coronary Heart Disease, Heart Attack, or Congestive Heart Failure.

**Emphysema, Chronic Obstructive Pulmonary Disease, or Chronic Bronchitis.

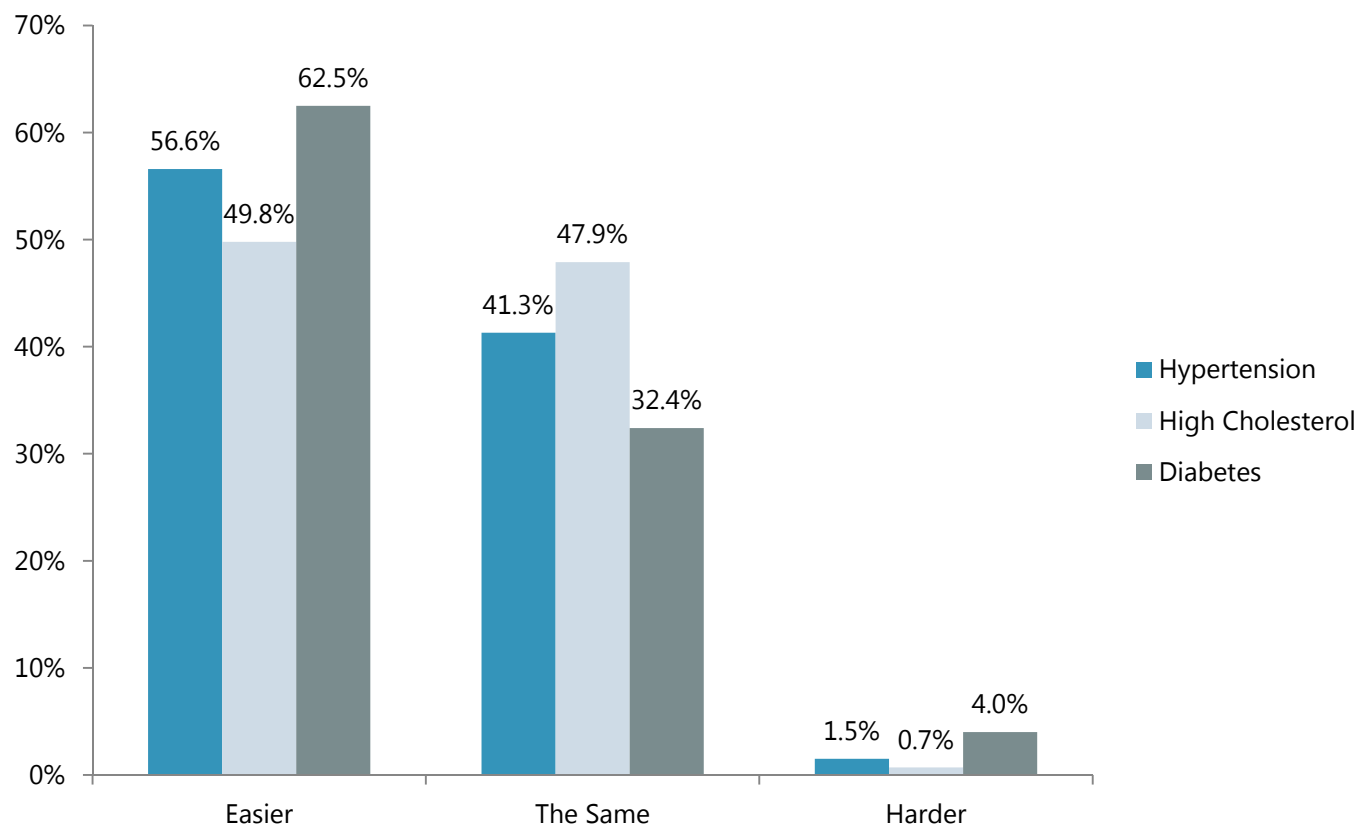
Source: Group VIII Telephone Survey.

2. Management of Chronic Conditions

As noted, many Group VIII enrollees (38.8%) had been diagnosed with a chronic condition prior to obtaining Medicaid coverage. However, prior to Medicaid expansion, many of these people were unable to obtain or afford appropriate medical treatment for these conditions.

After Medicaid expansion, as access to care improved and many Group VIII enrollees acquired a usual source of care, large percentages of Group VIII enrollees with preexisting chronic conditions reported that managing their conditions had become easier. Overall, 59.1% of individuals with a chronic condition reported that their condition was easier to manage after enrolling in Medicaid. Changes in ability to manage preexisting hypertension, high cholesterol, and diabetes are reported in Figure 15. As can be seen, more than half of Group VIII enrollees with these conditions reported that their condition had become easier to manage since enrolling in Medicaid, and very few people stated that managing their condition had become harder.

Figure 15. Changes in Ability to Manage Preexisting Chronic Conditions



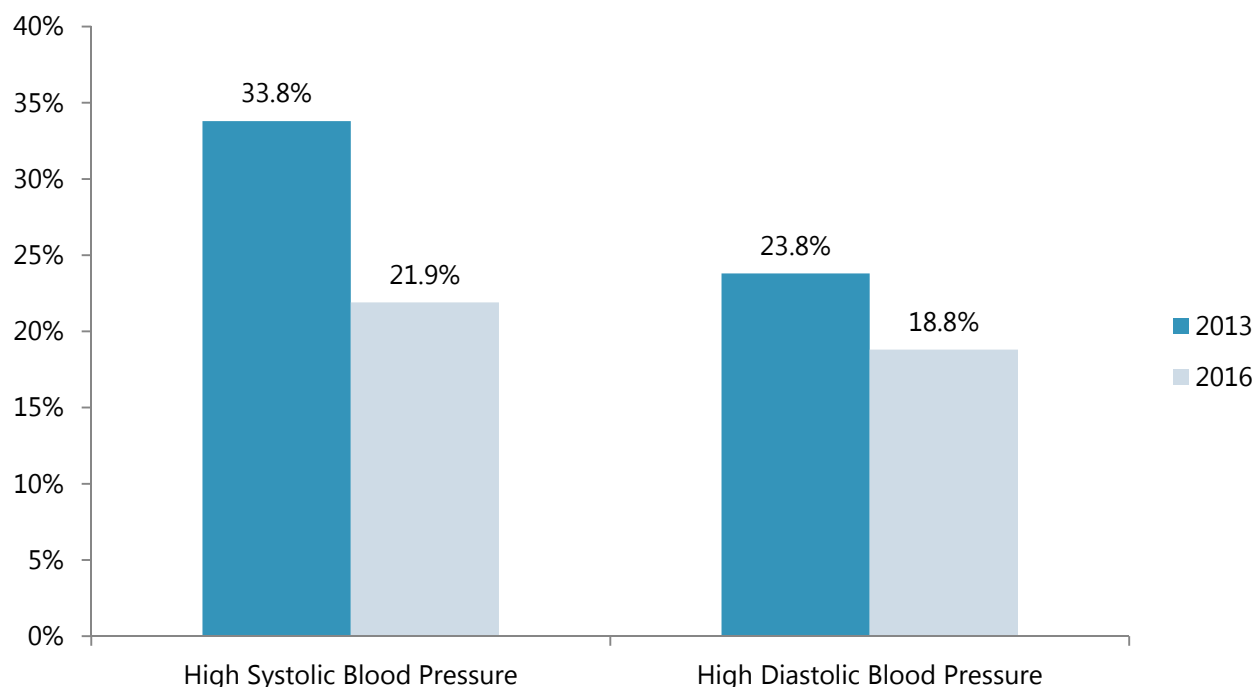
Source: Group VIII Telephone Survey.

Group VIII enrollees who participated in the medical records review were more likely to have appropriate care for their chronic conditions after enrolling in Medicaid. For example, among Group VIII adults aged 40 to 64 years with Type 2 diabetes who visited their usual source of care in both 2013 and 2015-2016, there was nearly a 50% relative increase for statin treatment between the two time periods (29%, up from 21%). Similarly, a substantially greater percentage of Group VIII enrollees diagnosed with depression were receiving antidepressant medications in 2016 (61%), compared to 2013 (48%).

In Medicaid claims data analyses, HEDIS-derived measures were used to assess whether Group VIII enrollees were receiving appropriate clinical care for their chronic conditions, and whether diagnosed risk factors were being effectively treated. As detailed in the Methodology Report, these analyses demonstrated that Group VIII enrollees are making progress in controlling chronic conditions and that Group VIII enrollees were receiving evidence-based treatments at roughly equivalent rates to pre-expansion enrollees. For instance, 79.6% of Group VIII enrollees with diabetes and high blood pressure had their blood pressure under control, compared to 80.5% of pre-expansion enrollees—blood pressure was analyzed because hypertension is a leading risk factor for cardiovascular disease.

Although Group VIII participants had only been enrolled in Medicaid for no more than 2 years, some improvements in physical health were detectable. For example, the medical records review found that, among participants with medical records from both 2013 and 2015-2016, the percentage of patients with high-risk levels of blood pressure (systolic readings of 140 mmHG or above) decreased from 33.8% to 21.9% (Figure 16). Similarly, the percentage of these Group VIII enrollees with a BMI of 40 or greater (very severe obesity) decreased from 17.9% to 16.3%, and the percentage with high-risk levels of cholesterol (240 mg/dL and above) decreased from 10.0% to 3.3%.

Figure 16. Percentage of Group VIII Enrollees in the Medical Records Case Study with High Blood Pressure



Source: Medical Records Case Study.

3. Self-Rated Health Statuses

Group VIII enrollees have experienced improvements in self-rated health statuses (general, dental, vision and mental health). Literature indicates that survey respondents' self-rated health status is a better predictor of overall and general health than many clinical observations.^{43,44,45,46} Since Medicaid enrollment, nearly half of Group VIII enrollees (47.7%) reported improvements in their general health status. Only 3.5% stated that their health had gotten worse, while 48.4% stated that their health remained the same. Sixty percent of those who received evidence-based treatment for their chronic conditions^{viii} reported improved health status, compared to 46.9% of those who did not receive evidence-based care. Of those reporting a usual source of care, 57.5% reported improved health status, versus 45.5% of people without a usual source of care.^{ix}

Compared to Group VIII enrollees, pre-expansion enrollees were less likely to report improvements in their general health status in the past 2 years. Pre-expansion enrollees were about as likely to report that their health had declined as improved, although a majority (65.8%) reported that their health stayed the same (Figure 17). This suggests that enrollment in Medicaid produces a short-term increase in self-rated health status, because people are able to obtain treatment for preexisting conditions (whether previously diagnosed or undiagnosed). As these conditions are managed, Medicaid enrollees—like the general population—are then less likely to report significant improvements in their health from year to year.

Many individuals reported, in response to the question about what getting Medicaid had meant to them, that their physical health, mental health, or quality of life had improved.

^{viii} HEDIS-derived measures, Statin Therapy for Patients with Diabetes and Statin Therapy for Patients with Cardiovascular Disease.

^{ix} Differences significant at $p < 0.001$.

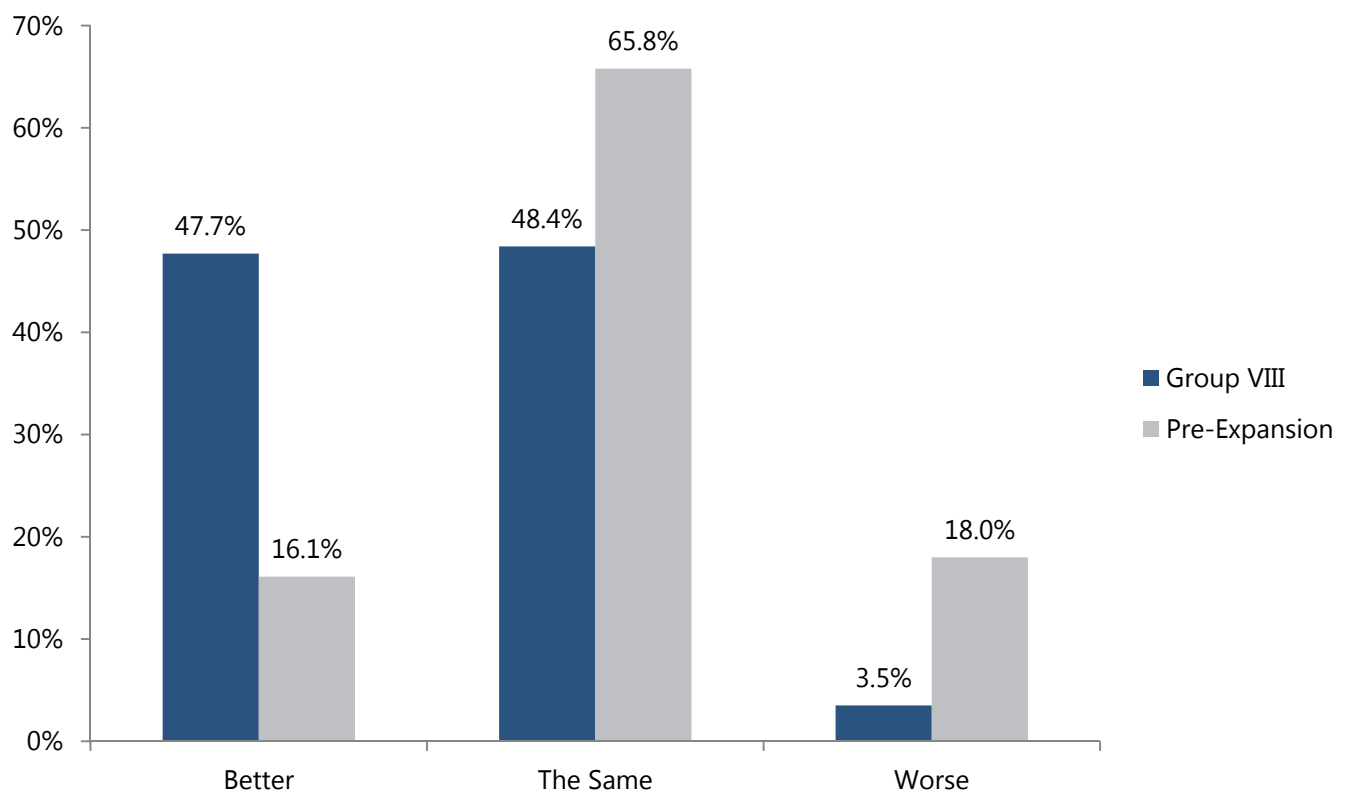
"It's meant that I can treat my Type 2 diabetes correctly, have it under control, which allows me to feel better, and work, and all around my quality of life has improved."

"[Medicaid has] been a godsend. I was diagnose[d] with diabetes and high blood pressure which I did not know I had, and I'm now on medication to take care of those two situation[s]."

"It has saved my life. I have severe mental issues and I have depression and bipolar insanity ADD (Attention Deficit Disorder) and I am on several medications and I would not be able to take care of me if I didn't have Medicaid."

Source: Group VIII Telephone Survey.

Figure 17. Changes in Self-Reported Health Since Enrolling in Medicaid (Group VIII Enrollees) or During the Past Two Years (Pre-Expansion Enrollees)



Source: Group VIII Telephone Survey.

Key Findings

More than one-quarter of Group VIII enrollees were diagnosed with a chronic condition after enrolling in Medicaid, suggesting a high level of unmet medical needs.

Medicaid has enabled those with chronic conditions to obtain evidence-based care. Medical records and Medicaid administrative data demonstrate that Group VIII enrollees are obtaining needed care for their chronic conditions.

Despite the limited time that has passed since Medicaid expansion, Group VIII enrollees are showing improvements in the management of their chronic conditions, including reductions in high-risk levels of blood pressure and cholesterol.

Self-rated health improved for Group VIII enrollees in Ohio; nearly half of all Group VIII survey participants reported that their health is now better than when they enrolled in Medicaid, compared to very few (4%) who reported that their health is worse.

Similar to this study, previous research examining Medicaid expansion has found that enrollment in Medicaid improves self-rated health and enables adults with chronic conditions to receive regular care for those conditions.¹

V. Changes in Mental Health

Individuals with mental illness historically have higher rates of chronic disease⁴⁷ and incur health care costs that are 2-3 times greater than individuals without these conditions.⁴⁸ This section identifies the incidence of these complex conditions for Group VIII enrollees and discusses whether they can effectively access treatment with their Medicaid coverage.

Data from this assessment confirmed that Group VIII enrollees with symptoms of mental illness had higher rates of chronic disease – there is evidence that these Group VIII participants are integrating into the health care system at rates comparable to or exceeding those of other Group VIII enrollees. Interviews with Medicaid providers suggest Medicaid expansion has greatly improved access to behavioral health care, but that limited numbers of available providers may pose a challenge in the future.

Several survey respondents mentioned access to mental health and behavioral health care when asked what Medicaid has meant to them.

"It's helped my mental health and I feel better about myself because I can get the care I need."

"It's meant I've been able to get treated for depression, get prescriptions, go to the doctor and get annual checkups. And dental and vision as well, I couldn't afford health care before."

"Medicaid has meant a great deal. It has enabled me to see my psychiatrist and family doctor. I'm grateful I have Medicaid."

"It has helped me get through the tough times I'm in, as far as getting help with alcohol addiction and mental health care."

Source: Group VIII Telephone Survey

1. Prevalence of Anxiety or Depression

Compared to pre-expansion enrollees, Group VIII enrollees had modestly lower rates of anxiety and depression. Over one-third of pre-expansion enrollees (35.7%) met survey screening criteria^x for depression, anxiety or both conditions compared to 31.9% of Group VIII enrollees. However, mental health conditions remain a barrier for employment within the Group VIII population, with 17.5% of Group VIII enrollees, compared to 22.5% of pre-expansion enrollees, reporting that a mental health condition kept them from work or other usual activities for 7 days or more in the last month. Overall, Group VIII enrollees meeting the screening criteria for mental illness had an employment rate that was half that of Group VIII enrollees without evidence of mental illness (28.8% versus 51.0%, respectively).

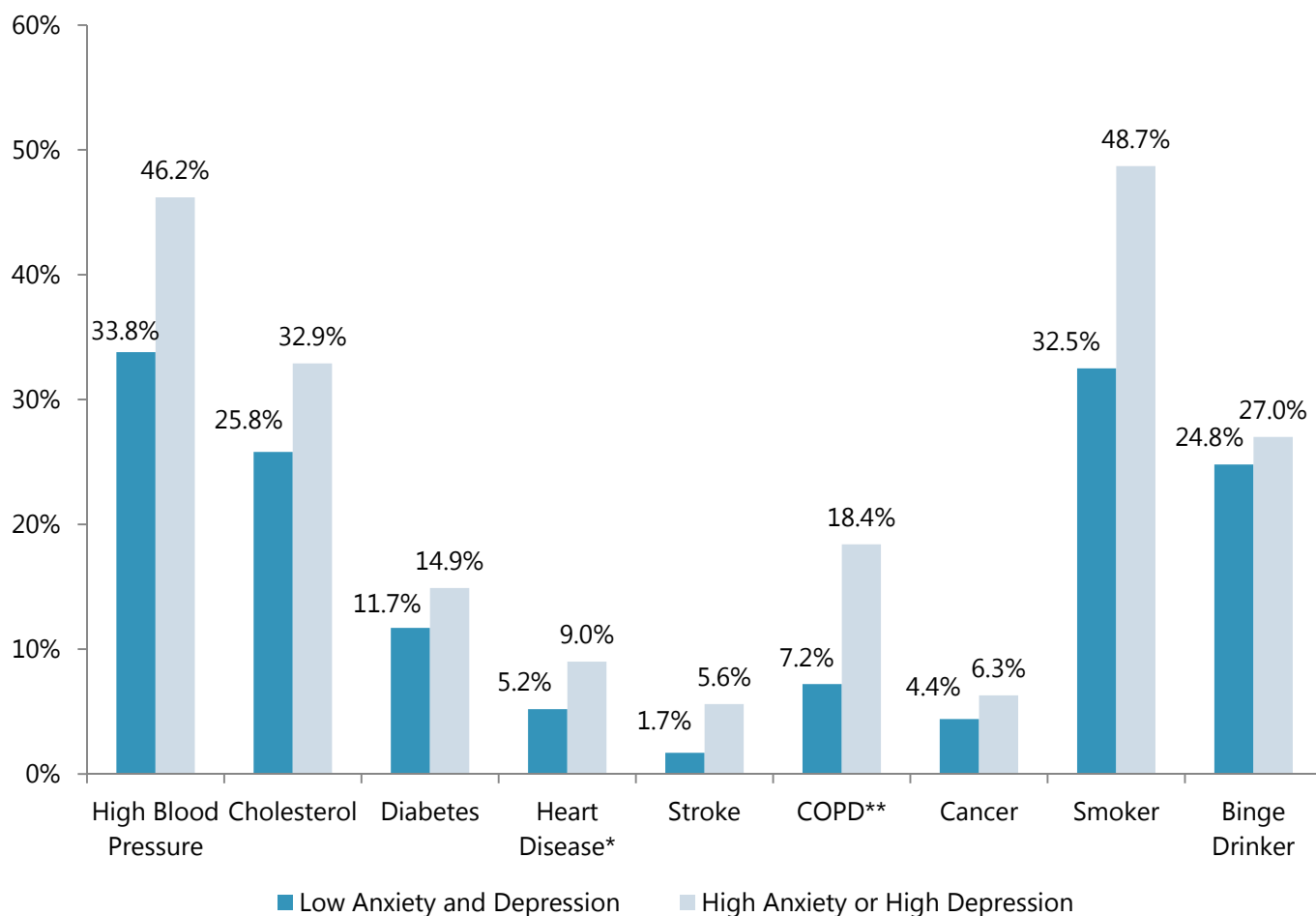
2. Mental Health and Chronic Disease Diagnoses

Consistent with prior analyses from the research team, Ohio Medicaid Group VIII Assessment findings suggest that Group VIII enrollees who met screening criteria for depression and anxiety had higher rates of chronic

^x A brief screening questionnaire on the PHQ4 standardized screening measure (Kroenke et al., 2010) was used to assess symptoms of depression and anxiety. High scores on this scale suggest that an individual is likely to meet the diagnostic criteria for depression or anxiety.

disease and risk behavior. Comparatively, Medicaid enrollees with a positive depression or anxiety screen were more likely to have a diagnosis for one or more of the following: high blood pressure, high cholesterol, diabetes, heart disease, stroke, chronic obstructive pulmonary disease, and cancer (Figure 18).

Figure 18. Percentage of Group VIII Enrollees With Chronic Condition Diagnoses by Mental Health Screening Status



*Coronary Heart Disease, Heart Attack, or Congestive Heart Failure.

**Emphysema, Chronic Obstructive Pulmonary Disease, or Chronic Bronchitis.

Source: Group VIII Telephone Survey.

3. Access and Utilization of Mental Health Treatment

The survey findings suggest that since Medicaid expansion, Group VIII enrollees with mental illness are making progress in obtaining needed mental health care. Close to half of Group VIII enrollees (44.0%) who met mental health screening criteria reported that access to mental health treatment had become easier, compared to 5.0% who indicated that access had become harder and 43.0% who indicated that it was the same.

Pharmacotherapy treatment for Group VIII enrollees met quality guidelines established by the National Committee for Quality Assurance for 61.7% of enrollees with a clinical diagnosis of depression during the acute phase of their illness, and for 50.9% during their continuation phase. Additionally, 29.4% used psychosocial treatments such as counseling, case management, care coordination, psychotherapy, or relapse prevention in the past year compared to 28.7% for pre-expansion enrollees (psychosocial treatment indicates assistance to psychological development in interaction with an individual's social environment).

4. Access and Utilization of Physical Health Care for Individuals with Mental Health Conditions

Since Medicaid expansion, Group VIII enrollees with mental illness are making progress toward obtaining needed medical care. As mentioned in Section III, 32.2% of Group VIII enrollees reported not having a usual source of care prior to Medicaid expansion. Group VIII enrollees who screened positive for anxiety or depression were more likely to obtain a usual source of care than those who did not screen positive (60.6% versus 57.3%). Those with evidence of a mental health condition also showed greater improvements in access to health care (68.5% versus 62.4%) and access to needed prescriptions (71.2% versus 62.5%).

Despite these results, many Group VIII enrollees who screened for anxiety or depression were more likely than other Group VIII enrollees to report going to the ED more often since enrolling in Medicaid (20.9% versus 13.4%).

5. Substance Use and Misuse

Considering substance use, Group VIII enrollees reported lower tobacco use than pre-expansion enrollees (37.9% versus 39.6%) but higher rates of binge drinking^{xi} (25.5% versus 20.5%). However, claims data showed equivalent rates of clinically diagnosed substance abuse or dependence (32.3% for Group VIII enrollees versus 33.8% for pre-expansion enrollees),^{xii} and equal rates of diagnosed opiate abuse and dependence (3.6% for each group).^{xiii} However, Group VIII enrollees were less likely than pre-expansion enrollees to receive prescriptions for medications associated with abuse and dependence, such as opioids and benzodiazepines (25.6% versus 32.0% for opioids, 10.4% versus 13.6% for benzodiazepines). (Literature and Ohio-specific studies indicate that opioid prescription reforms for pain conditions have lessened the prevalence of prescribing opioids.)

Those with substance use disorders were more likely to report improvement in overall access to care (72.1% versus 60.9%), access to prescription medication (74.4% versus 61.2%), and access to mental health care (44.7% versus 27.7%) than enrollees without substance use disorders. This improvement was even more evident for Group VIII enrollees with an opioid use disorder (75.4% versus 64.0% for overall access to care; 82.7% versus 64.8% for access to prescription medications; and 59.3% versus 32.2% for access to mental health care). This improvement in access to care since enrollment in Medicaid is consistent with research indicating improved access to treatment for opioid and other substance use disorders because of changes in state and federal health policies.^{49,50,51,52,53}

These findings suggest that many enrollees with substance use disorder do not receive substance abuse treatment. Only 29.9% for Group VIII enrollees and 28.8% for pre-expansion enrollees with substance use disorders receive psychosocial treatment for substance abuse and, based on pharmacy claims, only 17.9% for Group VIII enrollees and 21.0% for pre-expansion enrollees with opioid use disorders receive Medication Assisted Treatment.

^{xi} Binge drinking was defined as having more than four (for women) or five (for men) drinks on one occasion within the past 30 days.

^{xii} Including alcohol, cannabis, opioids, sedatives, hypnotics, anxiolytics, cocaine, stimulants, hallucinogens, inhalants, and other psychoactive substances.

^{xiii} This finding is based on diagnosed opioid use disorder, which is likely to be an underestimate of the actual prevalence of opioid use disorder.

6. Impact of Medicaid Expansion on the Mental Health and Substance Abuse Treatment System

Stakeholder interviews with behavioral health provider groups found a uniformly positive view of the Medicaid expansion, but stakeholders expressed concern about meeting the increased demand for services, including behavioral health services (particularly substance abuse treatment). In the past, there were not many options for low-income individuals to have coverage for substance abuse treatment. Enrollees with behavioral health issues are now able to get care for their chronic diseases, which are prevalent in this population. Additionally, Medicaid assists individuals with mental illnesses with obtaining housing and employment. Often, these social services contribute to recovery and improvement of mental illness.

Although demand on providers has increased, the supply of providers has remained stagnant. In some public settings, the number of providers has actually decreased because counselors now have more, higher paying options in the private sector.

Key Findings

Compared to pre-expansion enrollees, the Group VIII Telephone Survey screening questions indicated that Group VIII enrollees had modestly lower rates of anxiety and depression, but mental health conditions remain a barrier for employment within the Group VIII population.

Of Group VIII enrollees with positive screens for anxiety or depression, 44.0% reported that access to mental health treatment had become easier since enrolling in Medicaid, while 5.0% indicated that it had become harder.

Group VIII enrollees with evidence of mental illness were more likely to have chronic health conditions, but were integrating into the health care system as levels comparable to or exceeding those of other Group VIII enrollees.

Research from other states has similarly found that Medicaid expansion has increased access to mental health services.¹

VI. Changes in Financial Hardship and Employment

A goal of all health insurance is to assist in the reduction of family financial stress by providing people with a measure of financial security in the face of medical bills. Prior studies on Medicaid expansion have shown reduction of financial stress to be a key benefit of Medicaid expansion.¹ Research shows that reducing financial stress provides clear physical and mental health benefits.^{54,55,56} In addition, reduction of financial stress is associated with lower levels of child and domestic abuse, which reduces health care utilization, and people with less experience of trauma have lower levels of future chronic disease.⁵⁷

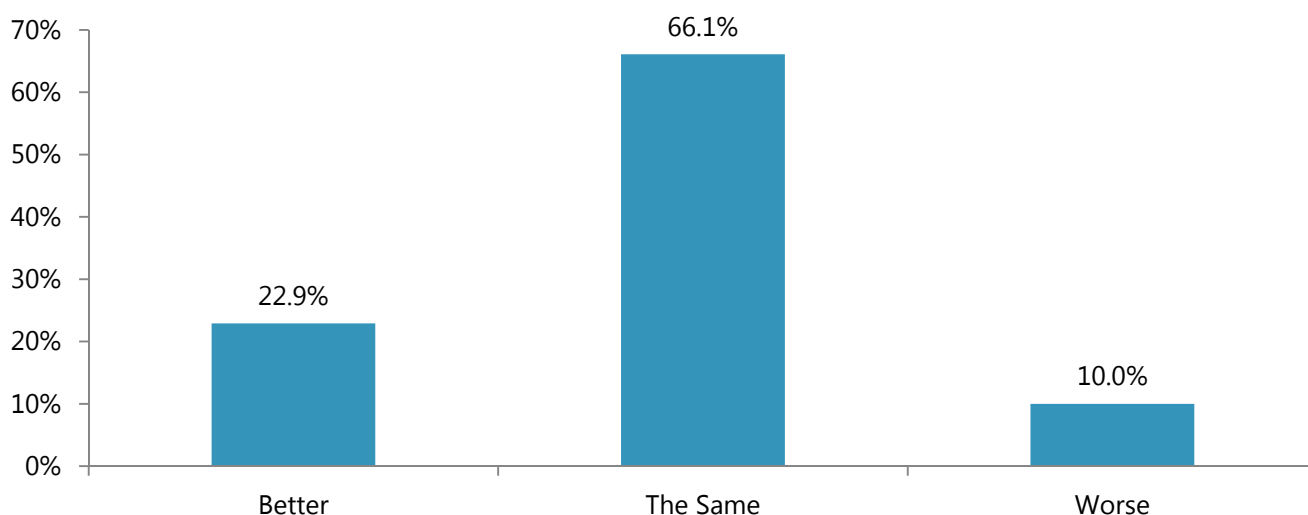
Medicaid reduces financial risks for recipients because it covers most medical costs. This can make household budgeting easier and less stressful because health care utilization and medical expenses are often unpredictable. Group VIII enrollees reported that Medicaid enrollment has enabled them to purchase basic necessities and pay down debt, supported their ability to seek employment, and reduced anxieties about seeking medical care.

1. Changes in Family Finances

Given that for many families health care costs are a major factor that influences household finances, Medicaid has the potential to reduce financial strain by facilitating access to needed care without large out-of-pocket costs.

Among Group VIII enrollees, 22.9% reported an improvement in their financial situation, 10.0% reported worsening finances, and 66.1% reported no change in financial position since enrolling in Medicaid (Figure 19). In other words, Group VIII enrollees, a financially distressed population, were nearly twice as likely to report that their finances were improving instead of worsening since obtaining Medicaid, although the degree to which this result is attributable to Medicaid (as opposed to other changes in a family's financial situation) is unknown. Group VIII enrollees who met screening criteria for depression and anxiety and those who were unemployed were the most likely to report that their financial situation had worsened since joining Medicaid.

Figure 19. Percentage of Group VIII Enrollees Reporting That Their Financial Situation is Better, Worse or the Same Since Enrollment



Source: Group VIII Telephone Survey.

One of the ways that Medicaid can promote financial well-being is by freeing up space in the family budget for other necessities, such as food or housing. A majority of Group VIII enrollees (58.6%) reported that it is easier to pay for groceries since getting Medicaid. Close to half of Group VIII enrollees (48.1%) also reported that since getting Medicaid it is easier to remain current on their rent or mortgage and pay off debt (43.6%) (Figure 20).

When asked what getting Medicaid meant to them, nearly one-quarter of Group VIII enrollees mentioned some sort of financial improvement in their household.

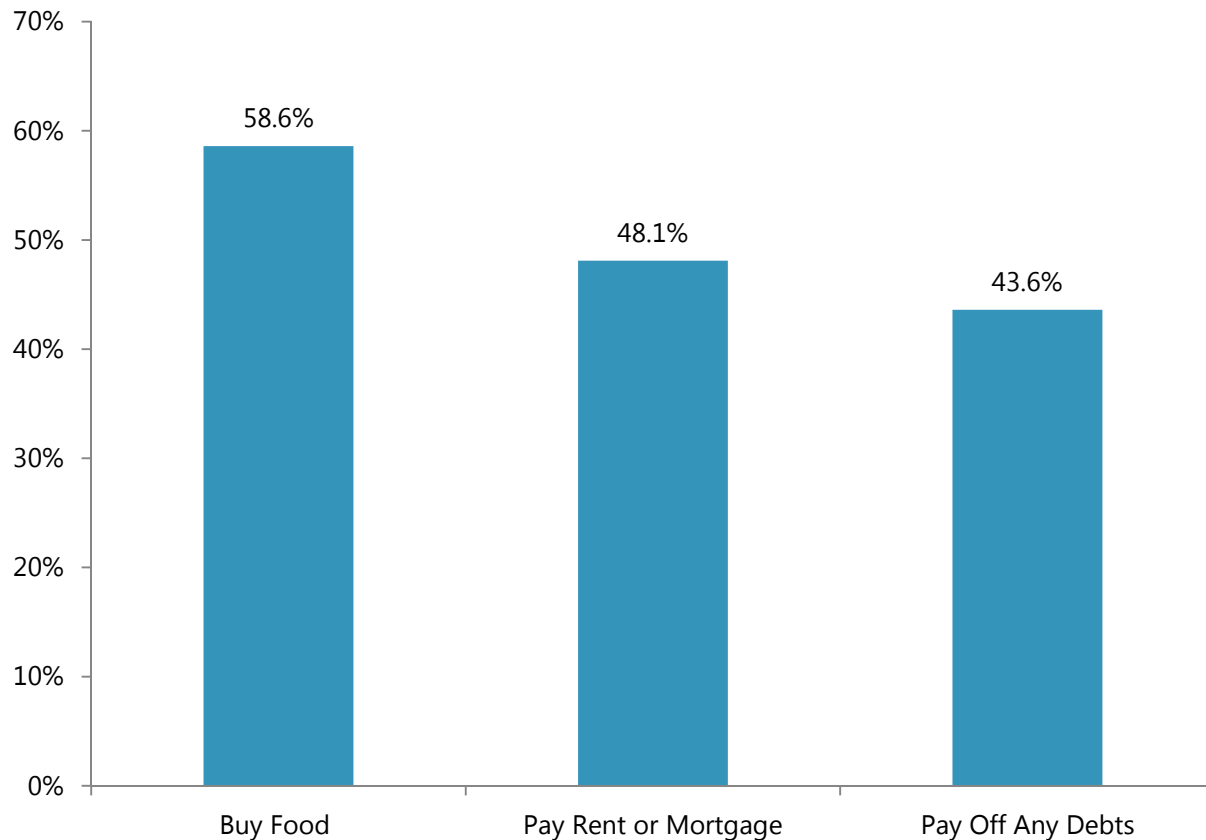
"It has meant me being able to afford food, and paying my rent, and me not worrying about paying for a doctor's visit."

"It has greatly helped me out financially and helped me put food on my table and survive."

"It has given us the freedom to see doctors now to be treated for medical reasons. It also has opened up that now we have more money left for our other expenses like food and such."

Source: Group VIII Telephone Survey.

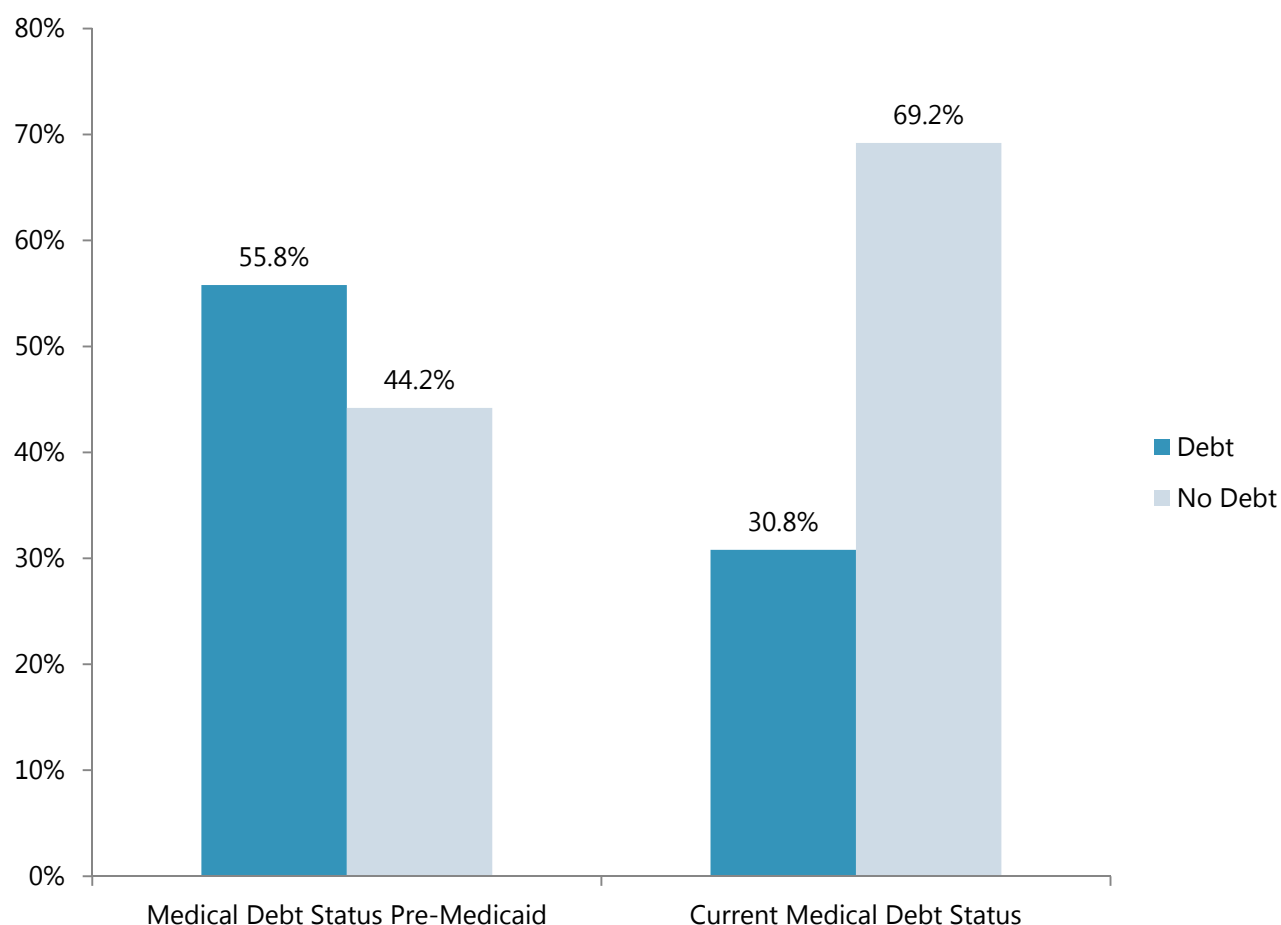
Figure 20. Group VIII Enrollees Reporting That it is Easier to Buy Food, Pay for Housing, and Pay off Debt Since Getting Medicaid Coverage



Source: Group VIII Telephone Survey.

Among the 55.8% of Group VIII enrollees who had medical debt prior to enrollment, 68.0% reported that these debts led them to fall behind on paying bills (Figure 21). At the time of the study, only 30.8% of Group VIII enrollees reported having any medical debt, a 44.8% reduction.

Figure 21. Percentage of Group VIII Enrollees With and Without Medical Debt Before and After Enrolling in Medicaid



Source: Group VIII Telephone Survey.

2. Employment

An additional question about Medicaid expansion is what, if any, influence it has on employment. Studies to date on employment and Medicaid expansion have not reached consensus concerning employment changes or reductions directly related to Medicaid coverage.^{58, 59} The Group VIII telephone survey collected information from enrollees on whether having Medicaid assisted in finding work or in maintaining existing work.

A majority of Group VIII enrollees reported that Medicaid has made it easier to secure and maintain employment. Among Group VIII enrollees who are currently employed, 52.1% reported that having Medicaid makes it easier to continue working (Figure 22). Among unemployed Group VIII enrollees looking for work, 74.8% reported that Medicaid makes it easier to look for work. For instance, one focus group respondent mentioned that she had a severe hernia and could not even get out of bed to go to work. After she enrolled in Medicaid, she had the needed surgery and could move around again. She was back to work and feeling much better. When asked what getting Medicaid meant, multiple survey respondents mentioned an improved ability to work when discussing their financial situation.

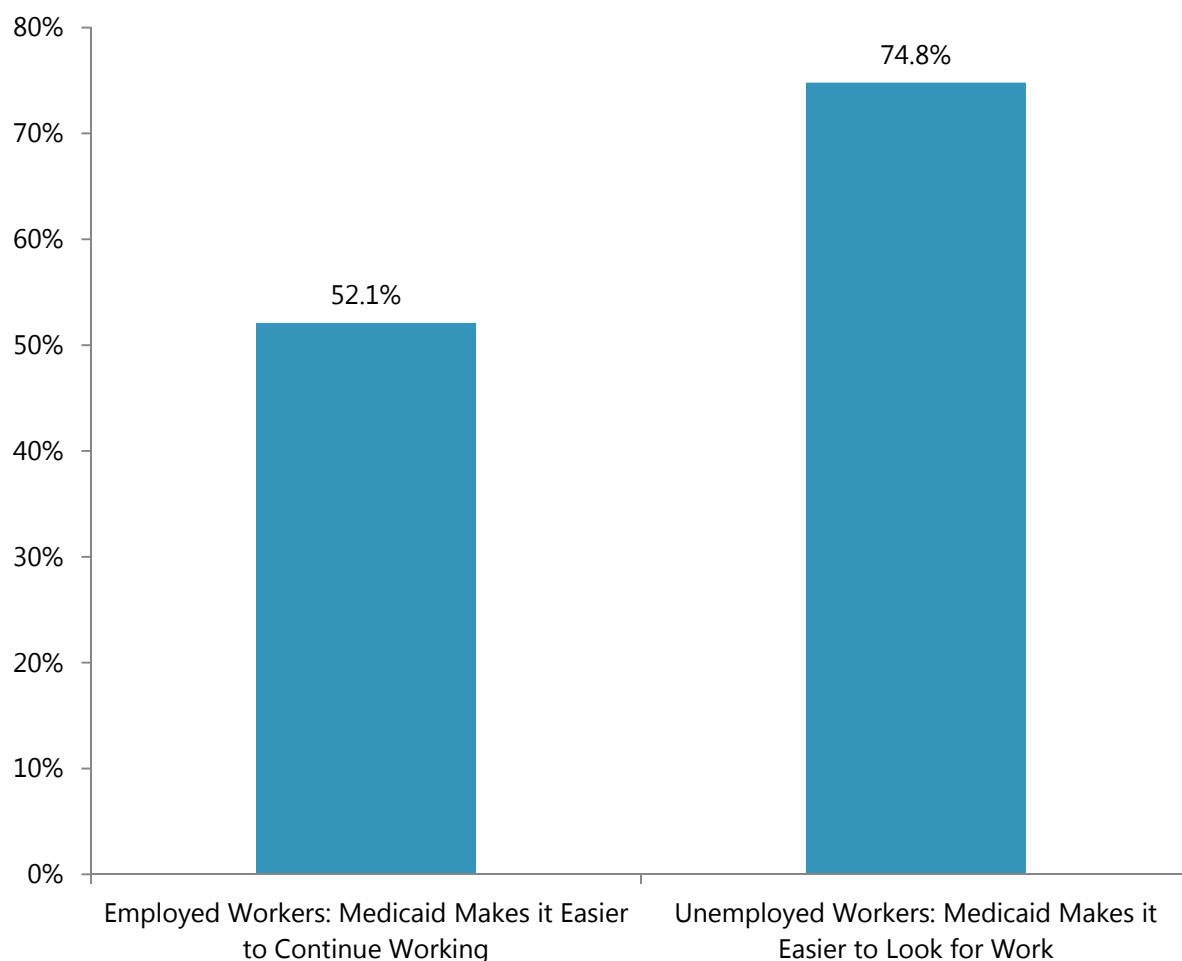
"I had a lot of health problems before but a lot had changed in my life. Now I am able to work more."

"I am finally getting everything that was wrong with me fixed so that I can go back to work. It's a great help."

"Give me the ability to seek employment without worrying about my health."

Source: Group VIII Telephone Survey.

Figure 22. The Effects of Medicaid Enrollment on Employment for Group VIII Enrollees

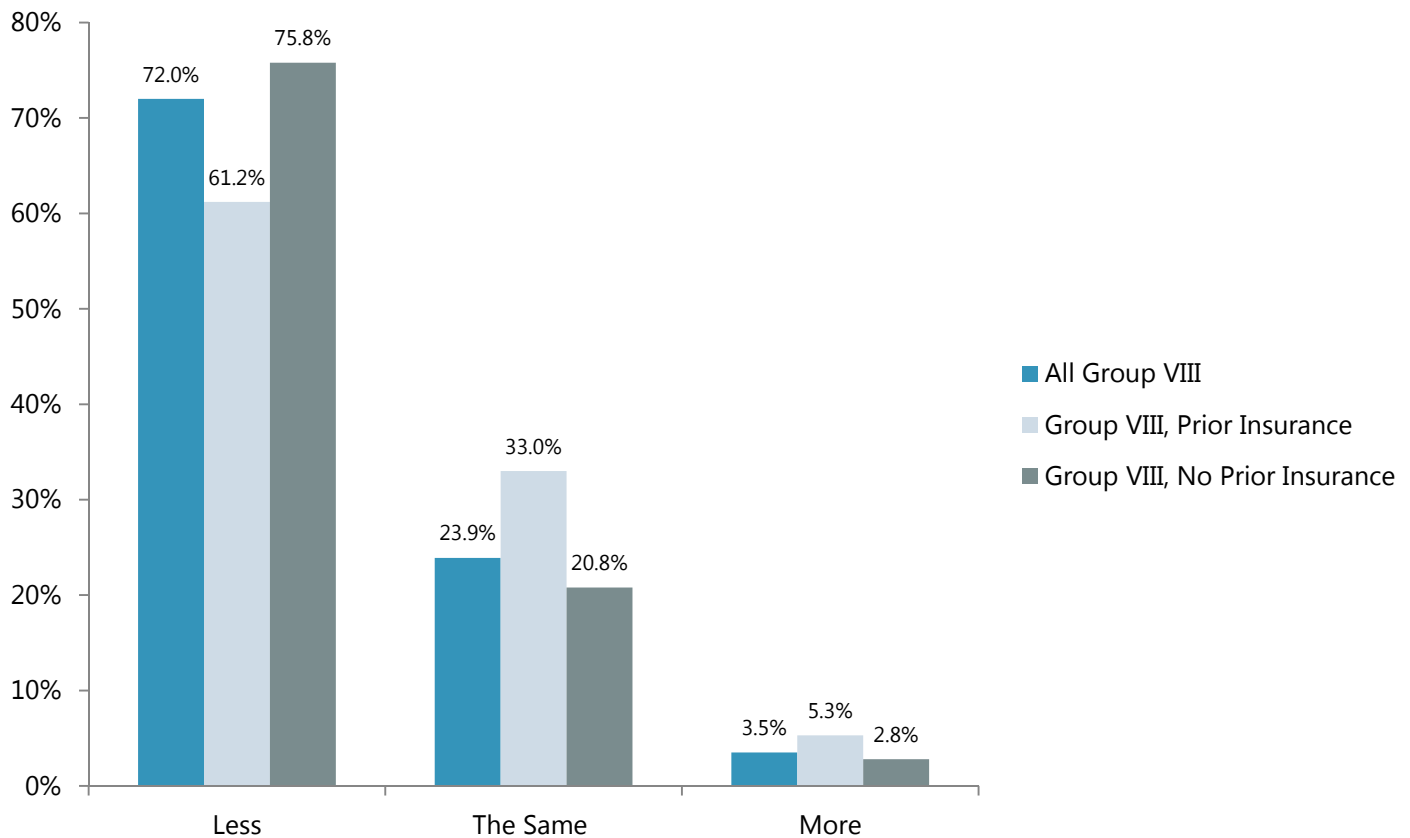


Source: Group VIII Telephone Survey.

3. Worry about Illness, Injury, and Medical Bills

By reducing concern about unaffordable medical costs, enrollment on Medicaid relieves anxiety about becoming ill or injured. Nearly three-fourths of Group VIII enrollees (72.0%) reported having less anxiety about becoming ill and having to go to a doctor since enrolling in Medicaid (Figure 23). Similarly, more than two-thirds of Group VIII enrollees (68.8%) reported less anxiety about getting injured and having to seek medical care.

Figure 23. Group VIII Enrollees' Worry About Getting Sick and Going to Doctor Since Getting Medicaid Coverage



Source: Group VIII Telephone Survey.

Likewise, a large majority of Group VIII enrollees (81.1%) reported that their worry about medical bills has declined since they obtained Medicaid eligibility (Figure 24). Even enrollees who had health insurance in the past reported less worry about medical bills. Over one-quarter of respondents (27.9%) mentioned “relief” in their response to the question about what getting Medicaid meant. Many of these individuals linked relief to less worry about bills.

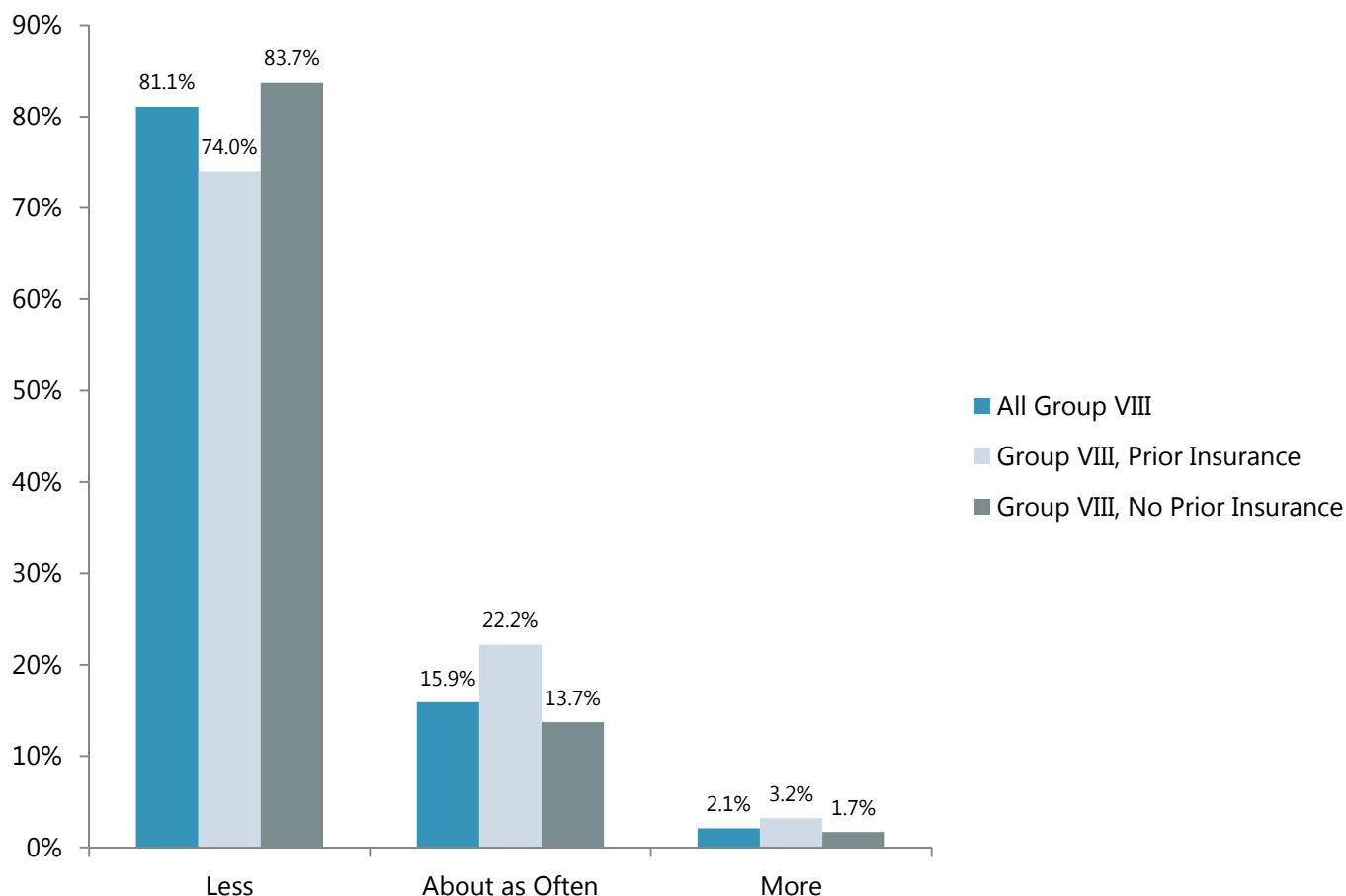
“It seems like less stress knowing when having an emergency you don't have to worry about not affording it or been refused services from a hospital.”

“[Medicaid] allows me to go to the doctor when I need to instead of not going. It’s less worrying about it. It helped me with my mental health.”

“It has been a blessing, without it I would be so far in debt from my cancer treatment and medical bills that I incurred. It’s been fantastic.”

Source: Group VIII Telephone Survey.

Figure 24. Worry About Medical Bills Since Medicaid Eligibility



Source: Group VIII Telephone Survey.

Key Findings

Participation in Medicaid has made it easier for Group VIII enrollees to pay for basic necessities including food and housing.

Medicaid coverage has enabled currently employed Group VIII enrollees to maintain their positions, and it has helped enrollees without jobs to seek employment.

The protection that Medicaid provides against unexpected and unaffordable medical costs significantly reduces enrollees' anxiety about becoming ill or injured.

These findings align with previous research from other states concluding that Medicaid expansion stabilizes participants' household finances, reduces unpaid medical bills and unpaid debt, and reduces stress associated with health care costs.¹ Reduction in stress is associated with improvements in self-rated health.
18, 60, 61

Prior research comparing expansion and non-expansion states have not found Medicaid expansion to have any significant effects on labor force participation.⁵⁹ Group VIII Medicaid enrollees in Ohio, however, believe that Medicaid enrollment has meaningfully enhanced their ability to find and maintain employment.

VII. Conclusions

Ohio's 2014 Medicaid expansion extended health care coverage to more than 702,000 low-income Ohioans as of May 2016. For Group VIII enrollees, access to Medicaid has facilitated access to care, reduced emergency department utilization, improved self-reported health, and supported employment and job-seeking.

In response to the General Assembly's request, this assessment has comprehensively reviewed the effects of Ohio's Medicaid expansion on Group VIII enrollees. This assessment drew on a wide range of data sources including a telephone survey of Medicaid participants, biometric screenings, medical records examinations, Medicaid claims and administrative data, and qualitative interviews. Detailed information about the methodology is included in the Ohio Medicaid Group VIII Assessment Methodology Report.

Key conclusions include the following:

1. Group VIII Participants

Prior to enrolling on Medicaid, most Group VIII enrollees (89.0%) had no health insurance coverage. Medicaid expansion has contributed to the lowest uninsured rate for low-income Ohioans ever recorded. In comparison to pre-expansion enrollees, Group VIII enrollees are more likely to be white, male, with a high school degree or less, and unmarried. They are also more likely to have been diagnosed with a chronic disease and to have at-risk levels of various health indicators.

2. Access and Utilization of Care

Medicaid has improved access to care. Large majorities of Group VIII enrollees report that obtaining care and filling prescriptions has become easier. Additionally inappropriate health system use patterns have shifted, with Group VIII enrollees reducing their use of EDs and connecting instead to usual and appropriate sources of health care.

The reviews of medical records and Medicaid administrative data confirmed that Group VIII participants were increasingly connecting to usual and appropriate sources of care, reducing ED utilization, and obtaining access to evidence-based treatments.

3. Physical Health

Nearly half of Group VIII participants (47.7%) reported that their health has improved since enrolling in Medicaid, compared to only 3.5% reporting worsening health. Those who allowed access to their medical records showed improvements in the treatment of chronic diseases and health risk factors. Since Medicaid enrollment, more than one-quarter of Group VIII participants (27.0%) have been diagnosed with at least one chronic health condition. Many of these chronic conditions would likely have remained undiagnosed and untreated without Medicaid expansion.

4. Mental Health

Approximately one-third of Group VIII enrollees met screening criteria for depression or anxiety disorders, which was slightly lower than the percentage of pre-expansion enrollees with anxiety or depression. These Medicaid participants reported higher levels of improvement in access to care than those without depression and anxiety, and they were more likely to connect to usual and appropriate sources of care after enrolling on Medicaid.

5. Financial and Employment

Enrollment on Medicaid has allowed Group VIII participants to pay for basic necessities such as food and housing, and to pay off medical debt. For example, 58.6% reported that enrollment in Medicaid has made buying food easier.

Group VIII enrollees overwhelmingly reported that having Medicaid coverage made it easier to look for work or to remain employed.

In survey responses, Group VIII enrollees stressed the importance of Medicaid enrollment to their health and their financial situation.

6. Providers and Stakeholders

Providers and stakeholders also discussed the positive impacts of Medicaid expansion and the role it had played in expanding access to health care for low-income Ohioans. Some providers and stakeholders did, however, object to the reimbursement rates provided by Medicaid—an issue that predates Medicaid expansion and is beyond the scope of this assessment.

Many reported that the access to care facilitated by Medicaid allowed enrollees to learn about and seek treatment for previously undiagnosed—and sometimes life-threatening—medical conditions.

7. Final Conclusion

In summary, the consensus of data collected in the Ohio Medicaid Group VIII Assessment is that Ohio's Medicaid expansion has been beneficial to Ohio's Group VIII enrollees in terms of the following:

- Expanding access to care
- Facilitating more appropriate forms of health care utilization
- Detecting previously undiagnosed health conditions
- Supporting employment and job-seeking
- Reducing financial hardship and medical debt

These results suggest that Medicaid expansion has and will continue to improve the health of low-income Ohioans enrolled in Medicaid expansion.

Note: The Ohio Medicaid Group VIII Assessment project was conducted by a partnership of the Ohio Colleges of Medicine Government Resource Center, The Ohio State University College of Public Health, Ohio University, and RTI International for submission to the Director of the Ohio Department of Medicaid. The content of this report is the responsibility of this partnership.

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