OHIO MEDICAID EXPANSION HISTORY AND IMPACT

Ohio Joint Medicaid Oversight Committee
March 20, 2025

Greg Moody, former director
Ohio Governor's Office of Health Transformation

Chairman Holmes, Ranking Member Liston, and members of the committee, thank you for inviting me. I'm Greg Moody, director of professional development at the John Glenn College of Public Affairs at Ohio State. Today, I am not representing Ohio State, but speaking from my prior experience as director of Ohio Governor John Kasich's Office of Health Transformation. That's the team that expanded Medicaid in 2014. Now, ten years later, I appreciate your interest in its history and impact on Ohio. Also, because it's budget season, I want to share two concerns in House Bill 96, Governor DeWine's kill switch on mental health and addiction services, and runaway spending that jeopardizes the expansion and coverage for everyone on Medicaid.

History of Medicaid Expansion in Ohio

Leading up to expansion, Ohio's health care system was in bad shape. 1.2 million people didn't have affordable health insurance. Without it, many delayed care or ended up in the emergency room. Hospitals passed the cost of unpaid care to private insurance, raising costs for employers. Every rural hospital was at risk of closing, and some did. Opioid addiction was rising, and county boards were the only source of public treatment services. They couldn't keep up, and many residents ended up in jail instead of treatment. Medicaid expansion mostly dealt with these problems, but if it goes away, the headlines will be back overnight. (Slide 1)

When Governor Kasich took office, Ohio was under a federal mandate to expand Medicaid (the Supreme Court made it optional later). Medicaid costs were growing 8.9 percent each year (2009-2011), faster than state revenue, and crowding out other budget priorities. We had to control spending before the mandate kicked in, or it would swamp the system.

The biggest risk to a stable Medicaid program is runaway spending. Back then, provider rates had been increased using one-time federal money. These increases were across the board, not targeted, and not tied to quality. There were too many managed care contracts (34) to be efficient and one of the most expensive categories, prescription drugs, had been carved out. Finally, this is not the case now, but it was then, waiting lists for home and community-based services were pushing seniors and people with disabilities into more expensive nursing homes. This resulted in 8.9 percent annual growth in Ohio Medicaid spending.

It took one year to roll back provider rate increases, tie payments to quality, rebid managed care into one efficient statewide region with five plans, include drugs in managed care, and help

10,000 Ohioans move from nursing homes into home and community-based settings. This resulted in 3.3 percent annual growth (2012-2013). When the Supreme Court made expansion optional in 2012, Ohio was in a good position to consider expanding Medicaid. (Slide 2)

Medicaid already covered children in families with income below 200 percent of poverty and parents below 90 percent. Seniors and people with disabilities could qualify based on income, but there was no help for adults ages 19 to 64. The Affordable Care Act (ACA) created a new Health Insurance Marketplace where individuals and families with income between 100 and 400 percent of poverty can get health plans with federal subsidies to make them affordable. But the Exchange alone looks incomplete because the ACA expected states to fill the gap by expanding Medicaid, but the Supreme Court made that optional, resulting in a coverage gap.

Without expansion, there's a fairness issue. Some Ohioans at higher incomes (100 to 400 percent of poverty) get help to buy insurance, while those with lower incomes (below 100 percent of poverty) get no help at all. In the past, there were some ugly mischaracterizations about who is in this gap, but I think we're past that now. Only U.S. citizens with a social security number and Ohio residents qualify for coverage under Ohio's expansion. Nearly everyone in the gap is either working, in school, taking care of a family member, or unable to work due to a chronic physical or mental health condition, often both. (Slide 3)

A coalition formed to support the expansion, including advocates for low-income Ohioans and hospitals, health plans, and other providers that would benefit financially. But the powerful voices were local chambers of commerce wanting to stop costing-shifting to businesses, county commissioners whose tax levies couldn't keep up with service demands, and sheriffs seeking treatment alternatives to jails. It gets your attention when a dozen sheriffs walk through your door insisting on expansion.

In response, a majority of Ohio House and Senate Republicans at the time supported expansion. I visited every member twice that year. However, there was little appetite for taking a vote that would be seen as supporting Obamacare in the next primary.

Speaker Bill Bachelder was against expansion but listened to his caucus and agreed to move it forward through Controlling Board. Ohio already had the authority to expand, granted by the federal government, but needed an appropriation to receive the federal funds, which the Controlling Board could grant. The Speaker removed his two members on the Controlling Board, both were against the expansion and running for Speaker, saying he didn't want to politicize the vote. He replaced them with one member who was for and one against the expansion. The final vote was 5-2 for the appropriation, giving Ohio the green light to expand. Today, Medicaid covers children up to 200 percent of poverty, everyone else up to 138 percent, and the Exchange provides subsidies for individuals and families up to 400 percent of poverty. (Slide 4)

So far, 40 states have adopted Medicaid expansion, half with Republican Governors, and none have discontinued their program.

Impact of Medicaid Expansion in Ohio

Right away, the expansion made a difference. Over 700,000 Ohioans got health care coverage, many for the first time, resulting in Ohio's lowest uninsured rate on record Ohio.[1] About half of the expansion group works 20 hours or more a week (49.6 percent). Most say Medicaid made it easier to work (84 percent), care for family (76 percent) buy food (58 percent), and pay rent (48 percent). Medical debt was cut nearly in half (from 56 to 31 percent). Common jobs include retail, food service, customer support, electricians, carpenters, home health aides, personal care aides, and medical assistants.[2] Before expansion, many workers caring for Medicaid patients had no coverage themselves, but now they do. (Slide 5)

Most people's health improved (31 percent) or stayed the same (59 percent). Primary care visits went up, and more providers joined Medicaid to meet the demand. As access to primary care increased, expensive emergency room visits went down (17 percent). Many (27 percent) found they had a chronic health condition they didn't know about and started life-saving treatment.

Over the first four years of expansion, 630,000 people got treatment for mental illness or substance use disorder (2014 to 2018). This helped them find and keep jobs. One in ten had a substance use disorder, and nearly eight percent had an opioid use disorder. Expansion funds much of Ohio's public behavioral health treatment capacity, at least $500 million annually.

Impact of Medicaid Expansion on Ohio's Budget

Beyond the clear financial and health benefits for enrollees, Ohio's Medicaid expansion brings billions of federal dollars into the state every year. Last year, Ohio spent $838 million to draw $7.5 billion in federal funds, totaling $8.4 billion. This money goes directly to health care providers across the state, boosting Ohio's economy.

At first, it looks like ending Ohio's expansion would save $838 million (the state share). But it also would add new costs and sacrifice revenue. The expansion saves at least $68 million by converting state-funded programs to 90-percent federal funds, for example hospital stays for prisoners and hospital upper payment limit programs. The state also would lose at least $72 million in drug rebates and $415 million in managed care taxes. The real impact on the budget is closer to $250 million, or about 3.4 percent of the total cost. (Slide 6) In other words, for every 3.4 cents Ohio spends on expansion, it buys one dollar of health care services.

I know mental health and addiction services are important to Governor DeWine and the legislature. If the expansion ends, it will cost at least $500 million to replace the lost services, nearly double the amount the state would save by ending expansion.[3] (Slide 7) Keeping the expansion means keeping all current services, including mental health and addiction services.

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[1] Information in this section is from *2018 Ohio Medicaid Group VIII Assessment*, Ohio Department of Medicaid (August 2018).
[2] *The future of Group VIII (expansion) Medicaid coverage in Ohio*, Health Policy Institute of Ohio (March 14, 2025).
[3] Ohio Medicaid does not report this information. This estimate is based on health plan reports of behavioral health spending for Group VIII, but likely underestimates spending, and should be updated for accuracy by Ohio Medicaid.

Impact of Ohio's Budget on Expansion

House Bill 96 threatens the Medicaid expansion in two ways. First, Governor DeWine added a kill switch on mental health and addiction services that could wipe out a decade of progress if federal funding drops by even one dollar. Second, runaway spending not related to the expansion puts the expansion and everyone on Medicaid at risk.

Mental Health and Addiction Services Kill Switch

Section 126.70 says, if federal funding for the expansion group drops below 90 percent, then the department "shall immediately discontinue" the program, including $500 million for mental health and addiction services. I wonder how the Administration was pushed into adding a kill switch to one of its top priorities. I've heard the kill switch described as just for show because it codifies a trigger that's already in place, but that's not true. The state plan amendment that authorized expansion says the state "can" end coverage, not "shall," and it doesn't tie coverage for 770,000 Ohioans to what might happen in Washington.

Right now, the mood in Washington is not to cut Medicaid. Last week, the White House said, "The Trump Administration will not cut Medicaid." U.S. Congressman Jim Jordan said, "We're not looking to make cuts to Medicaid." After the House approved a budget resolution that might cut Medicaid, Ohio Senator Bernie Moreno said the Senate won't support those cuts. "Republicans are not going to cut Medicaid benefits at all," he said.[4] (Slide 8)

That aligns with nine out of ten Americans who have a personal or family connection to Medicaid and say it's important to their community (Slide 9). They are not saying leave it the same, for example most support work requirements (Slide 10), but they don't want to tear it down. This is especially important in rural counties where expansion supports a greater share of the population and is vital for critical access hospitals. These hospitals are represented by 44 Republican House, Senate, and Congressional districts, and one Democrat. (Slide 11)

One possible outcome is that the federal government doesn't cut Medicaid spending, and Governor DeWine's kill switch doesn't go off, but that's risky. A safer option would be to change "shall" to "may" in Section 126.70, letting the state weigh its options if federal funding changes. Another option is to rely on the other trigger included in the budget. Section 126.10 says the state "may reduce, discontinue, pause, or suspend" any program if federal funding for that program is cut. Maybe one trigger is enough, and you can delete 126.70.

Runaway Spending

My concern about the kill switch is not a defense of the status quo. Runaway spending in House Bill 96 on top of runaway spending in the last budget needs to be addressed. The following

[4] *Press Release*, The White House (March 11, 2025), Jim Jordan Interview (at 6:00 minutes), Fox News Sunday (February 23, 2025), *Ohio Senator Bernie Moreno vows Senate GOP won't cut Medicaid*, News 5 Cleveland (February 26, 2025)

slides are based on the *Ohio Department of Medicaid Caseload and Spending Report*,[5] which I commend this committee for requiring with the department's budget submission.

Medicaid spending almost doubles under the current Administration, from $26.8 billion in 2019 to $51.1 billion in 2027. (Slide 12) All funds spending, including federal share (in gray) and state share (in red), goes up 8.9 percent on average each year from 2024 to 2027. If we zoom in, state share, including general revenue funds (solid red) and non-GRF (shaded red), increases 12.8 percent on average each year (2024 to 2027). (Slide 13) Zoom in all the way, and state GRF increases 11.1 percent on average each year (2024 to 2027). (Slide 14).

What drives spending? Usually, when caseload goes up, spending goes up. And when caseload goes down, spending goes down. Ohio's Medicaid caseload increased during expansion and COVID. (Slide 15). When you compare the rate of change in caseload (the red line) and spending (the blue line), there's a clear link. For example, in 2015, caseload went up 22.3 percent because of the expansion, and spending went up 12.5 percent. When caseload decreased in 2012, 2016, 2019, 2022, and 2023, spending also went down. However, in this budget and the last, caseload decreased, but spending defied the trend and increased significantly. (Slide 16)

If caseload isn't driving spending, what is? We've ruled out the expansion because its impact on the Medicaid budget is $283 million (FY 2024), about half of one percent of total. The main drivers of spending in this budget are state share increases to backfill one-time federal funds, significant provider rate increases, and Medicaid department projects.

Backfill one-time federal funds

If the state share of Medicaid grows faster than revenue, it will push out other budget priorities. But if it grows slower than revenue, it's sustainable. For nearly a decade (2013 to 2021), the state's share of Medicaid spending (red line) grew slower than state revenue (dotted line). The spike in 2012 happened because the prior Administration used one-time federal funds for permanent provider rate increases during the Great Recession (green line 2009 to 2011), and that required backfilling with state funds in 2012. After that, thanks to Kasich reforms, Medicaid state share grew slower than revenue, staying in the sustainability zone for a decade. (Slide 17)

In the last budget, one-time federal funds were again used for permanent provider rate increases, and that again required backfilling with state funds in 2024. From 2023 to 2024, the state share of Medicaid spending went up $2.3 billion (24 percent), which by the way is about eight times the cost of the expansion.

Provider rate increase

Provider rate increases added $9.6 billion to Ohio Medicaid spending in this budget and the last. The state's share is $3.2 billion. If you froze those increases in this budget, it would save the state $1.7 billion, which is about six times the cost of expansion. (Slide 18)

[5] Medicaid Caseload and Expenditure Forecast Report, Ohio Office of Budget and Management (February 3, 2025).

Sometimes, rate increases are needed, like when there are waiting lists for services. In the last budget, basically any category of direct care worker needed an increase. But giving everyone a rate increase, including hospitals and nursing homes, was a huge expense without good reason. Once you give that away, it's hard to take back. To save real money in this budget, you'd have to take it from hospitals, PhRMA, and nursing homes, and in my experience, that's only possible during a budget crisis. Realistically, this comes due in the next Administration. (Slide 19)

Medicaid NextGen projects

Finally, the Medicaid department has a suite of projects called NextGen that affect the budget. The NextGen managed care procurement in 2023 continued the Kasich program redesign in 2013, but added administrative costs by increasing plans from five to seven. OhioRISE, which oversees youth with complex behavioral health needs, is $70 million over budget and serving 40 percent fewer youth than planned.[6] According to department staff, the NextGen fiscal intermediary, a new centralized claims payment system, isn't paying claims.[7] But the biggest NextGen impact on the budget is the single pharmacy benefit manager (SPBM).

Ohio's SPBM has an interesting history, but I'll focus on the budget. After a three-month startup, Ohio Medicaid expected the SPBM to spend $396 million each month from January to June 2023. But actual spending was $56 million more each month, and after nine months, the SPBM was $585 million over budget. Instead of cutting costs, the Medicaid department added $84 million to its monthly budget, totaling $1 billion more over a year. Now, the department claims savings, but that's only compared to the higher projection. (Slide 20)

Final Thoughts

In 2014, Ohio expanded Medicaid to tackle the lack of affordable health insurance, crowded emergency rooms, cost shifting to businesses, and the opioid crisis. Today, 770,000 Ohioans benefit from the expansion. It supports work, keeps rural hospitals open, and provides access to much of the state's mental health and addiction treatment infrastructure.

The expansion has a small impact on the state share of the budget but brings in billions of federal dollars. The bigger risk is runaway spending from relying too much on one-time federal money and across-the-board provider rate increases. We've seen these problems before. (Slide 21) It's frustrating to be in the same situation again, but it also means we've dealt with these issues before, so we can handle them now or will have to if there's a budget crisis.

Thank you for taking the time to understand the history and impact of the Medicaid expansion in Ohio. Many people rely on it to get the care they need to work, care for their families, and stay healthy. The stewardship and responsibility to keep it going rests with you. Thank you.

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[6] Source: Ohio Medicaid Budget Variance Reports (January 2025), 29,976 enrolled Ohio Medicaid Caseload Report (February 2025), and 50,000 proposed Press Release, Ohio Governor Mike DeWine (July 1, 2022).

[7] IT problems with Ohio's Medicaid system impacting payments to healthcare providers, WOSU (March 6, 2025).

Slide 1.

Ohio's Health Care Crisis – Headlines Before Expansion

- 1.2 million in Ohio struggle without affordable insurance
- Uninsured residents delay care until crisis hits
- Uninsured Ohioans flood ERs as last resort
- Hospitals shift unpaid bills to private insurance, employers
- Rural hospitals sink under the weight of uncompensated care
- A wave of opioid addiction overwhelms county resources
- Without treatment, mentally ill and addicted end up in jails

Source: Ohio Governor's Office of Health Transformation Newsroom (2011-2014).

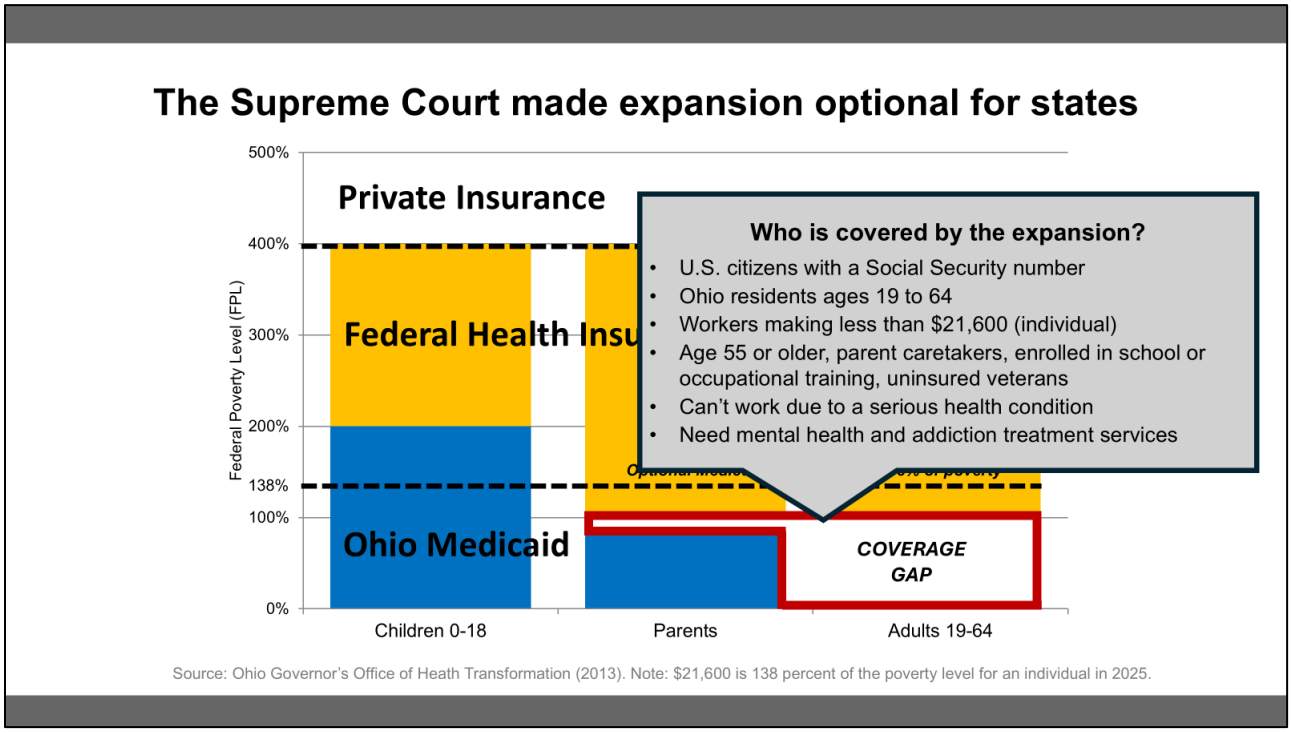
Slide 2.

Ohio Medicaid Budget Challenges and Reforms

2009 - 2011	2012 - 2013
Over reliance on one-time federal money	Backfill one-time federal funds with state share
Across-the-board provider rate increases	Roll back provider rate increases
Payment not tied to quality	Implement value-based payment incentives
34 inefficient health plan regions	Create one statewide managed care region with 5 plans
Prescription drugs carved out of managed care	Carve prescription drugs back into managed care
No coordination between Medicare and Medicaid	Integrate care for most dual eligibles (MyCare)
Few alternatives to high-cost nursing homes	Enable 10,000 NF residents move back to their community
8.9 percent annual growth	**3.3 percent annual growth**

Source: Ohio Governor's Office of Health Transformation (2014).

Slide 3.



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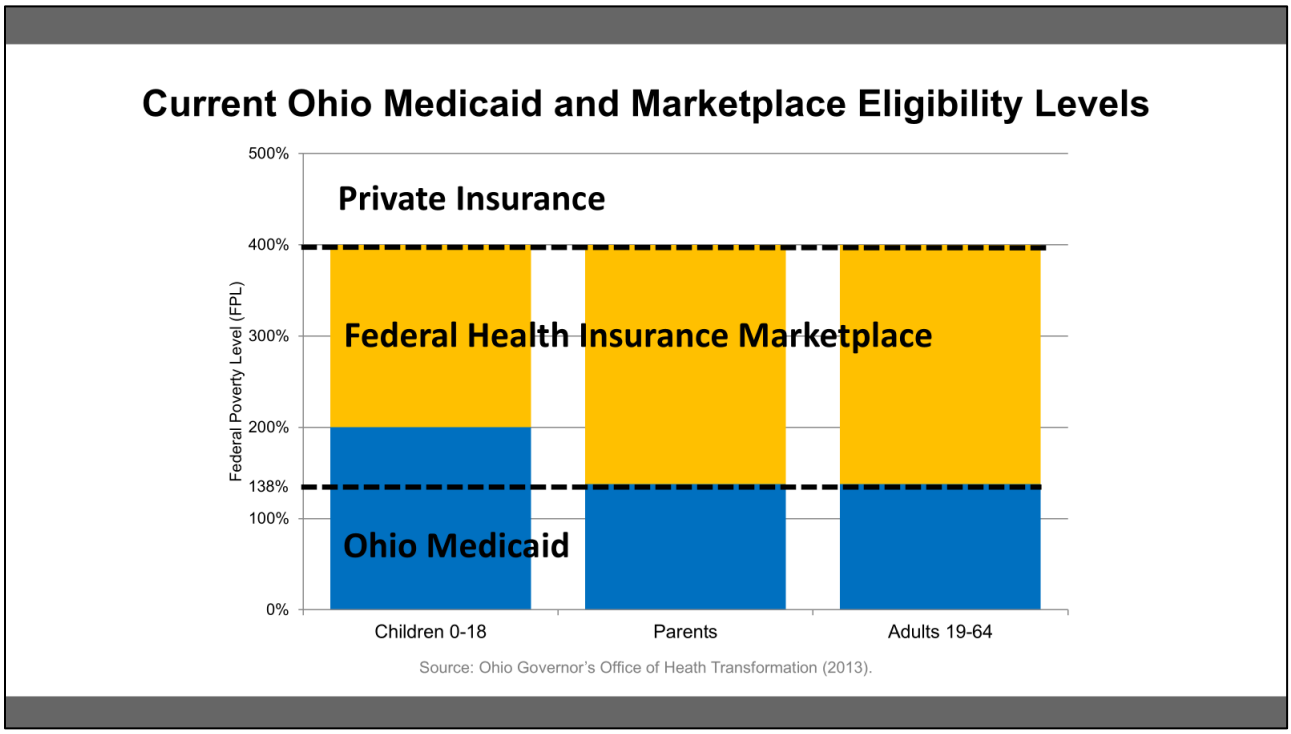


Slide 5.

Coverage Works

Over 700,000 Ohioans gained access to health care coverage under the expansion, resulting in:

- a large decline in the uninsured rate to the lowest level on record (19% in 2010 to 6% today
- most reported Medicaid coverage made it easier to working (84%)
- it was easier to care for family members (76%), buy food (58%) and pay rent (48%)
- medical debt fell by nearly half (from 56% to 31%)
- health status was better (31%) or the same (59%) for most and worsened for a few (10%)
- improved access to primary care and reduction in unmet medical needs
- high-cost emergency department use decreased (17%)
- many (27%) detected previously unknown chronic conditions

Source: *2018 Ohio Medicaid Group VIII Assessment*, Ohio Department of Medicaid (August 2018).

Slide 6.

Ohio Medicaid Expansion Net Fiscal Impact, FY2024

	(in millions)	
This much state share (10%)	$838	
Draws this much federal share (90%)	$7,538	
And results in this much expansion spending (100%)[1]	**$8,375**	
Medicaid expansion costs this much in state share	$838	
But saves this much by converting state-funded programs to 90% federal[2]	($68)	These amounts are estimated and need to be updated by Ohio Medicaid
And generates this much in prescription drug rebates[3]	($72)	
And generates this much in managed care taxes[4]	($415)	
So, the net fiscal impact of the expansion on Ohio's budget is	**$283**	
And the effective matching rate for Ohio's state share is	*3.4%*	

Notes: (1) Medicaid Caseload and Expenditure Forecast Report (page 9), Ohio Office of Budget and Management (February 3, 2025). (2) Includes corrections medical expense savings ($32 million, calculated using OhioCheckbook) and hospital upper payment limit programs ($36 million, calculated by the Office of Budget and Management in 2018 for FY 2021). (3) Office of Budget and Management estimate in 2018 for FY 2021. (4) Ohio Medicaid does not release this information. This amount is based calculations by Wakely Actuarial Consulting for health plan Group VIII franchise fees ($269 million) and health insuring corporation taxes ($58 million), and my estimate of SPBM Group VIII franchise fees ($88 million).

Slide 7.

Eliminating Ohio's Medicaid expansion might save the state $283 million,

but it would **forfeit $8.4 billion** that goes directly to health care providers across communities statewide,

including a **$500 million cut** in critical mental health and addiction treatment services statewide.

Notes: (1) Medicaid Caseload and Expenditure Forecast Report (page 9), Ohio Office of Budget and Management (February 3, 2025). Ohio Medicaid does not report behavioral health spending for Group VIII. This estimate is based on health plan reports of behavioral health spending for Group VIII but should be updated by Ohio Medicaid.

Slide 8.

"The Trump Administration will not cut Medicaid. President Trump himself has said it (over and over and over again)."

— White House Press Release

"We're not looking to make cuts to Medicaid."

— U.S. Congressman Jim Jordan

"Republicans are not going to cut Medicaid benefits at all."

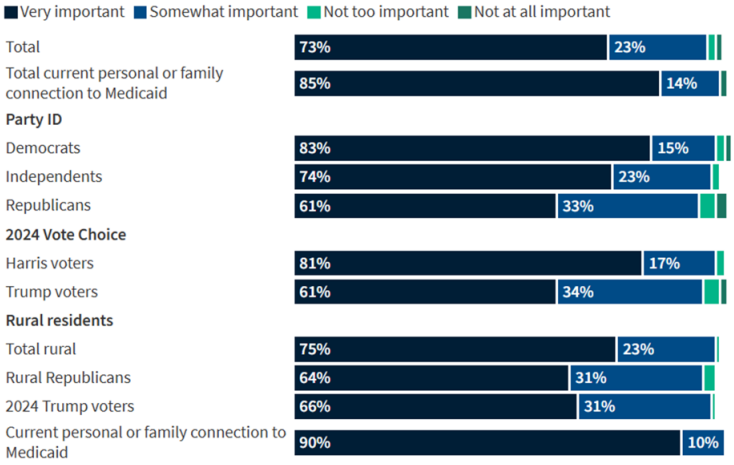
— Ohio Senator Bernie Moreno

Source: *Press Release*, The White House (March 11, 2025), Jim Jordan Interview (at 6:00 minutes), Fox News Sunday (February 23, 2025), *Ohio Senator Bernie Moreno vows Senate GOP won't cut Medicaid*, News 5 Cleveland (February 26, 2025)

Slide 9.

9 in 10 say Medicaid is important to their local community

"How important, if at all, is Medicaid for people in your community?"

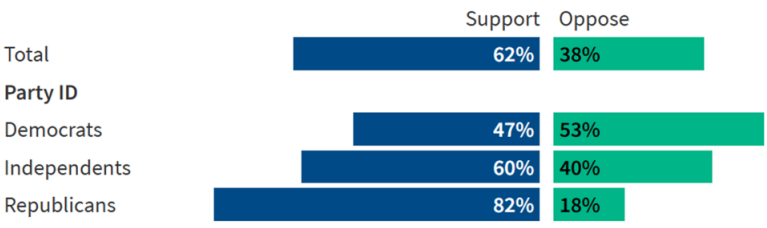


Source: The Public's Views on Potential Changes to Medicaid, Kaiser Family Foundation Health Tracking Poll (February 18-25, 2025).

Slide 10.

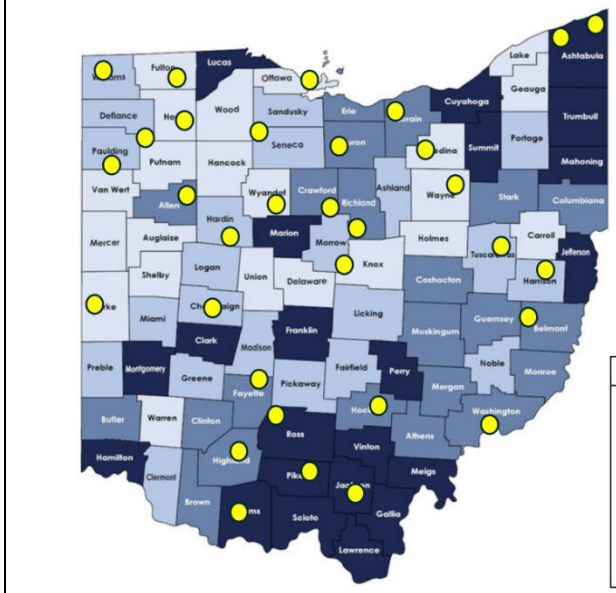
Most support Medicaid work requirements

"Do you support or oppose requiring nearly all adults to work or be looking for work in order to get health insurance through Medicaid?"



Source: The Public's Views on Potential Changes to Medicaid, Kaiser Family Foundation Health Tracking Poll (February 18-25, 2025).

Slide 11.



Percent of County Population Enrolled in Medicaid Expansion, January 2025 and location of Critical Access Hospitals

Lowest percent (1.6% – 4.4%)	Second quartile (4.5% – 5.5%)	Third quartile (5.7-7.2%)	Highest percent (7.3-11.7%)

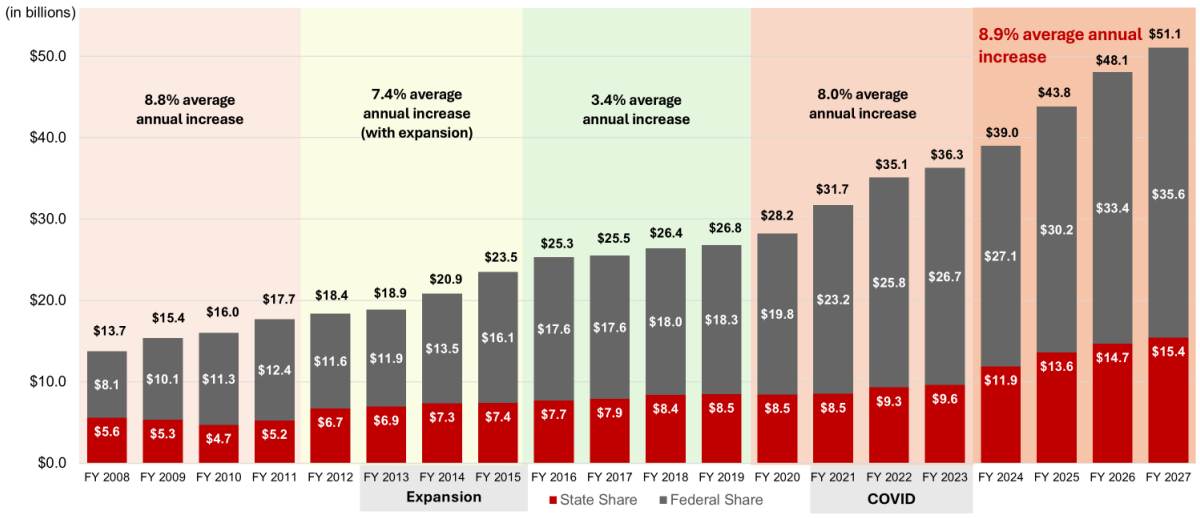
Location of Critical Access Hospitals by Ohio Congressional, House, and Senate District

Congress	Ohio House		Ohio Senate
David Taylor (6)	Jodi Salvo	Tim Barhorst	Rob McColley (6)
Jim Jordan (4)	Kellie Deeter (2)	Riordan McClain (3)	Theresa Gavarone
Bob Latta (8)	Adam Bird	Gary Click	Susan Manchester (3)
Michael Rulli (4)	David Thomas	D.J. Swearingen	Nathan Manning (2)
Max Miller (2)	Sharon Ray	Justin Pizzulli	Terry Johnson
Warren Davidson (1)	Marilyn John	Bob Peterson (3)	Shane Wilkin (6)
Marcy Kaptur (4)	Meridith Craig	Mark Johnson	Mark Romanchuk (2)
David Joyce (2)	Matt Huffman	Jason Stephens	Bill Reineke (4)
Mike Carey (1)	James Hoops (3)	Kevin Ritter	Brian Chavez (3)
Bernie Moreno (32)	Roy Klopfenstein (2)	Don Jones (2)	Al Landis
Jon Husted (32)	Ty Matthews	Sarah Fowler Arthur	Sandra O'Brien (2)
	Angela King		

Source: Health Policy Institute of Ohio analysis of Ohio Department of Medicaid Demographic and Expenditure Dashboard, and U.S. Census Bureau, American Community Survey 2023 5-year estimates (February 19, 2025) and Critical Access Hospital Locations Map, Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine (accessed March 6, 2025).

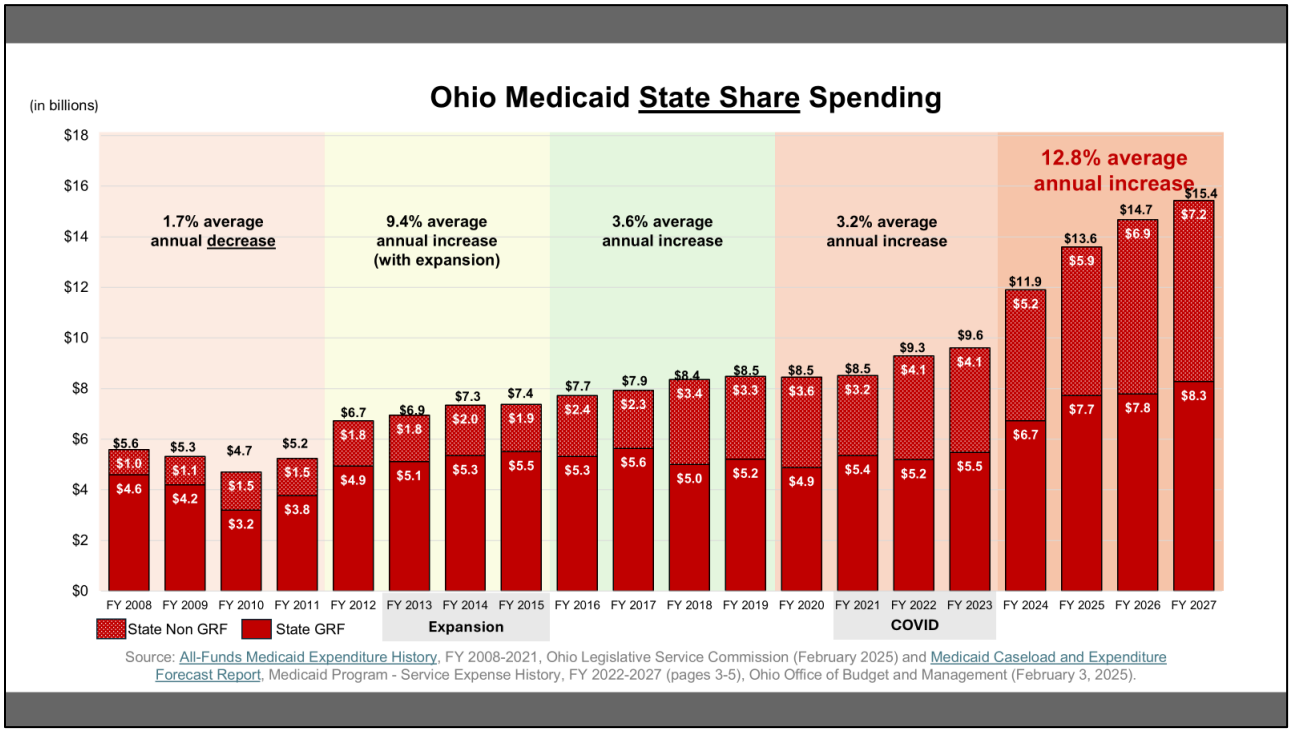
Slide 12.

Ohio Medicaid All Funds Spending



Source: All Funds Medicaid Expenditure History, FY 2008-2021, Ohio Legislative Service Commission (February 2025) and Medicaid Caseload and Expenditure Forecast Report, Medicaid Program - Service Expense History, FY 2022-2027 (pages 3-5), Ohio Office of Budget and Management (February 3, 2025).

Slide 13.



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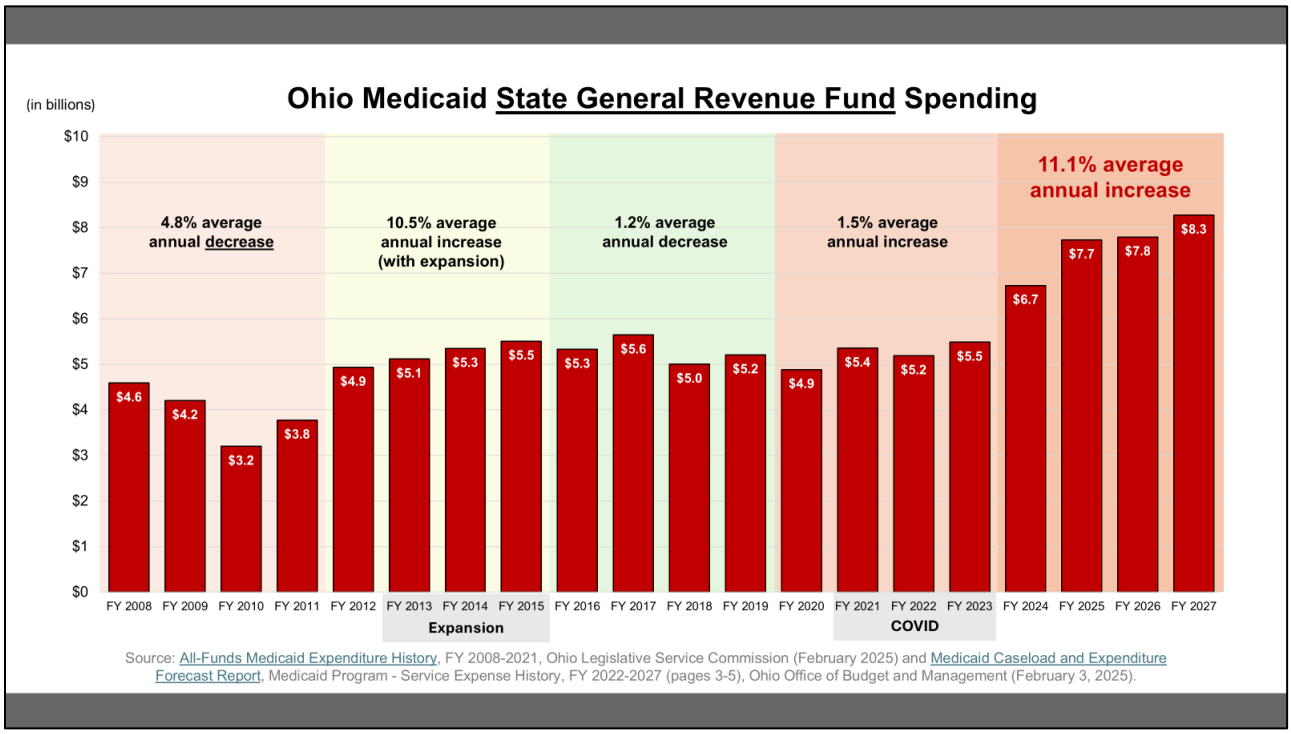

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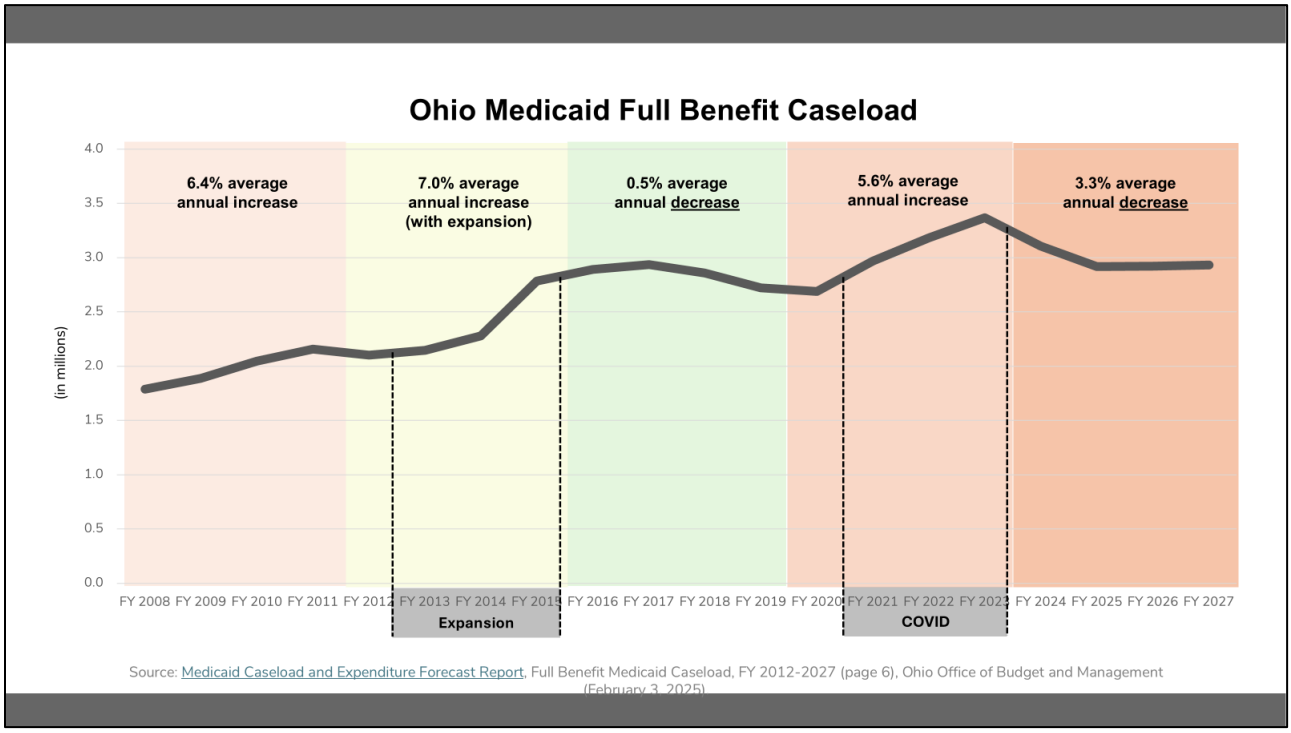

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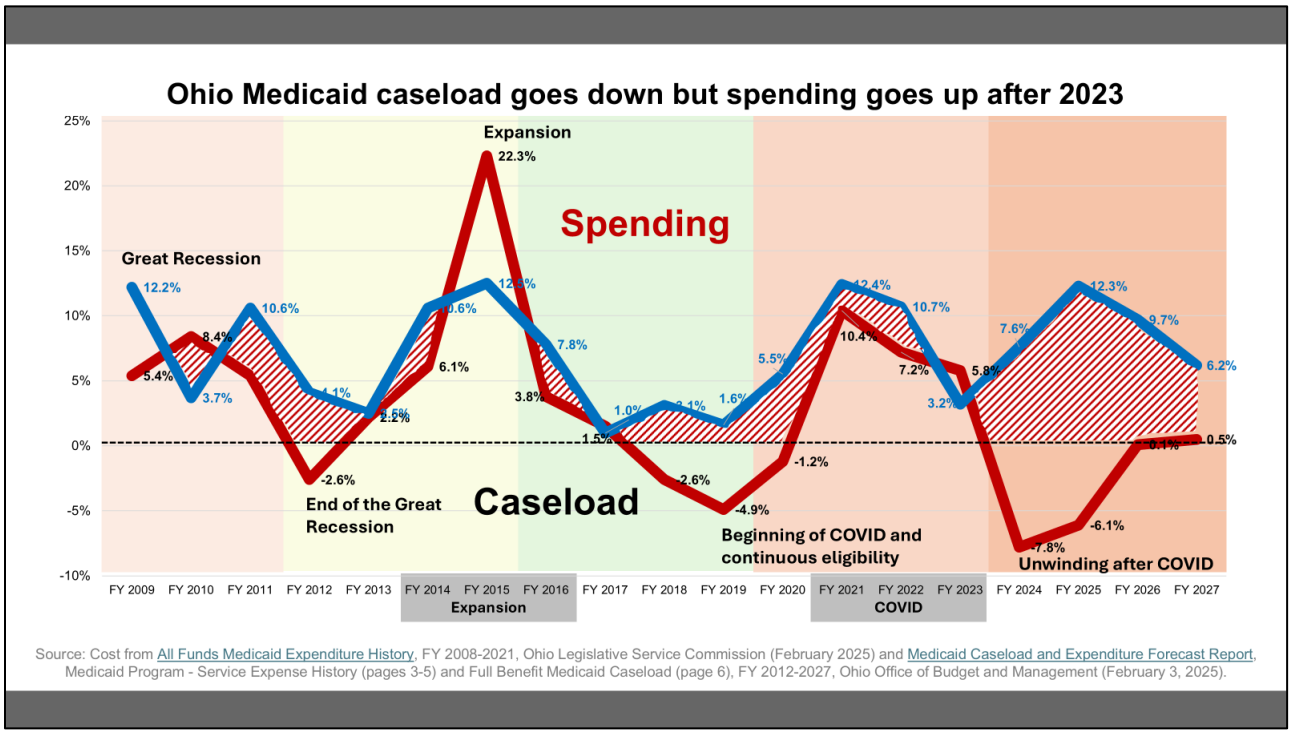

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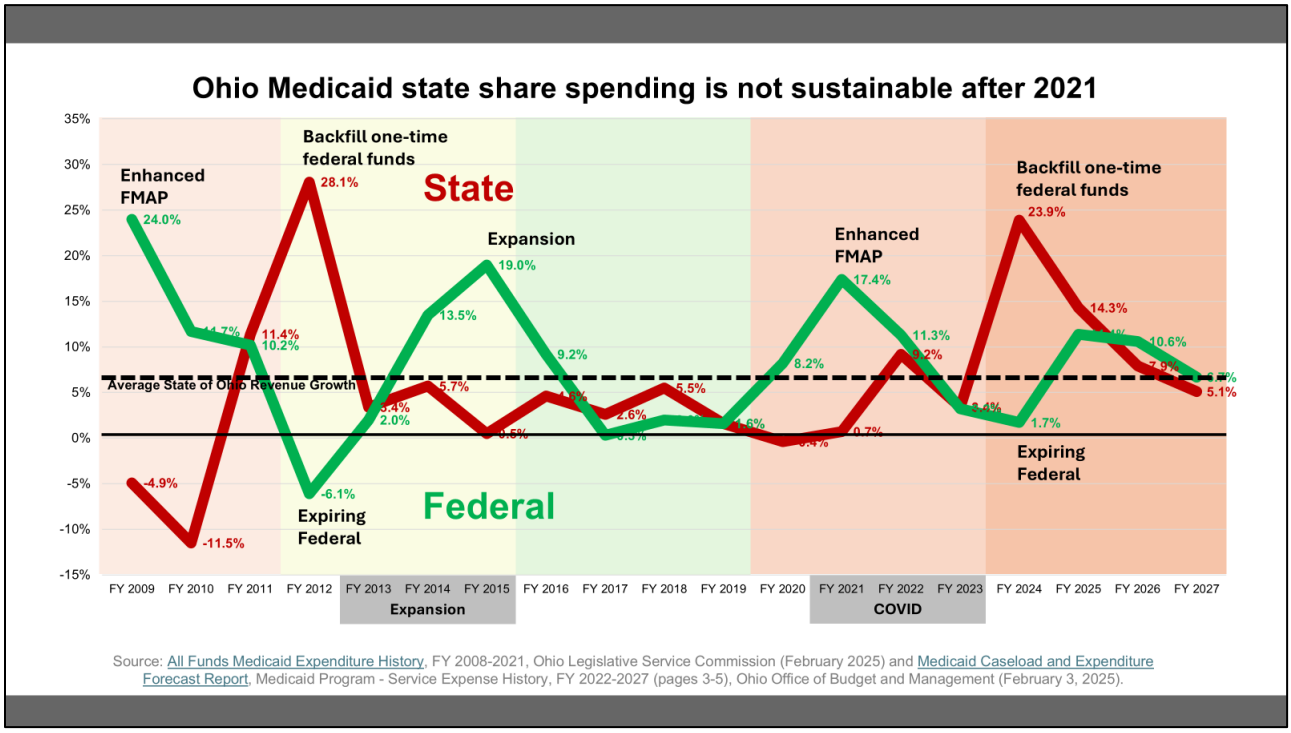

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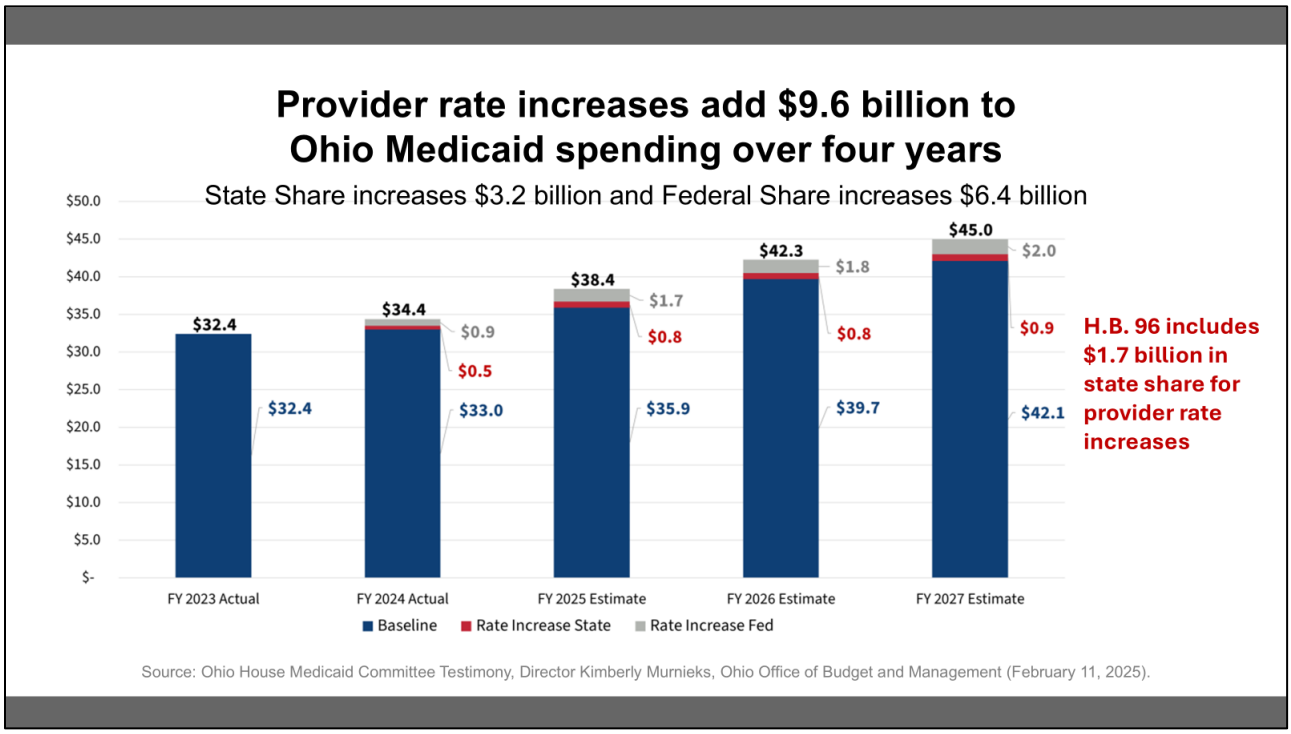

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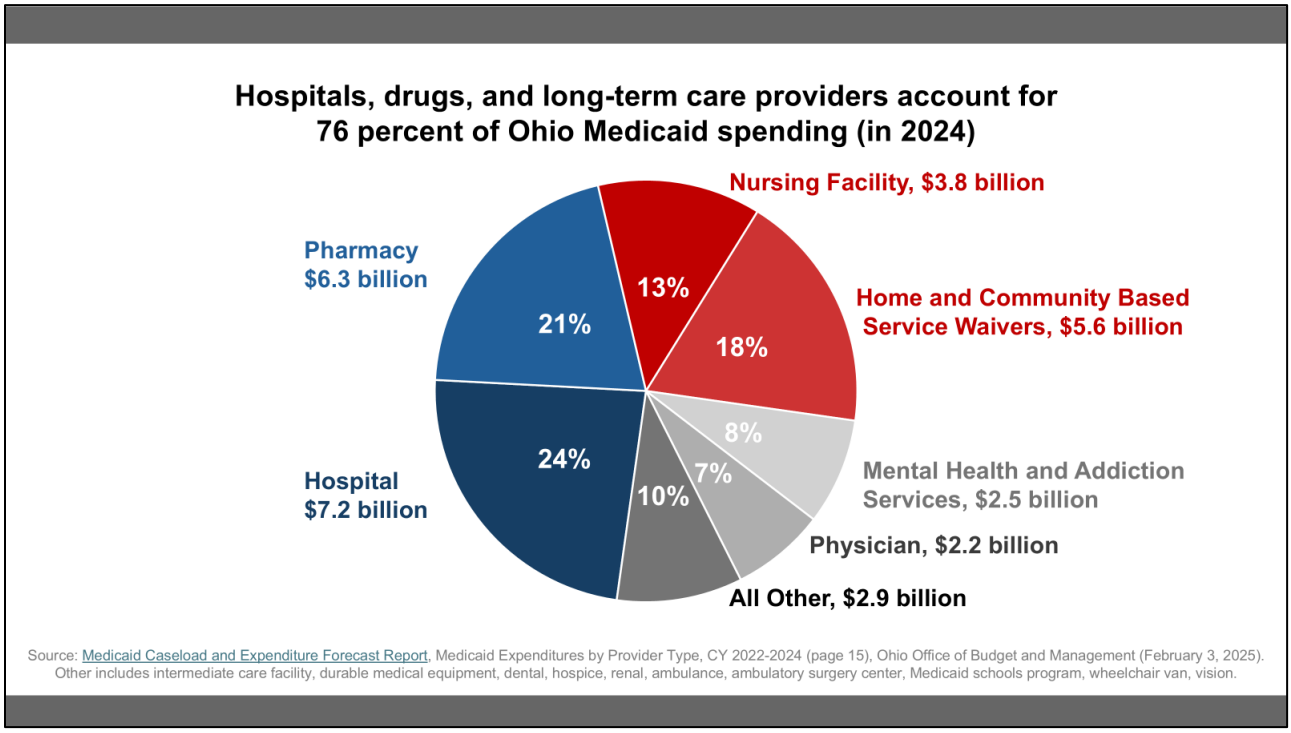

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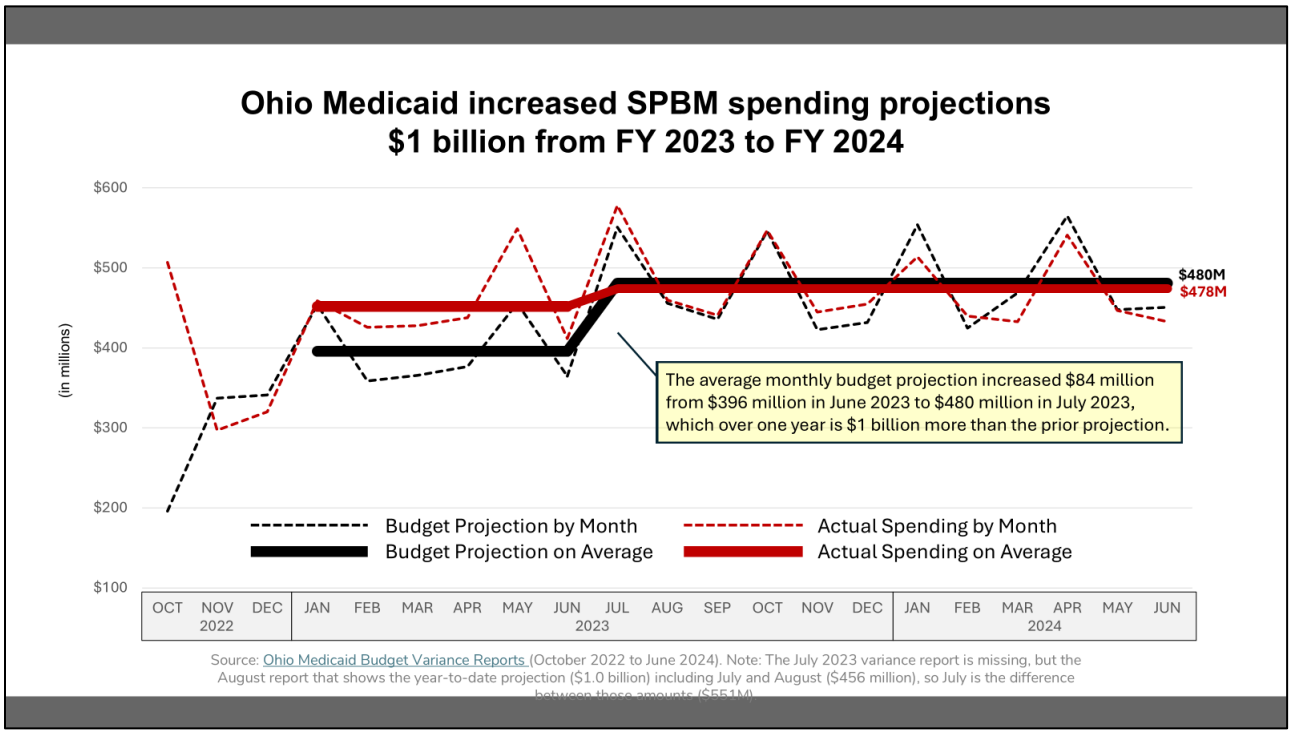

Slide 21.

Ohio Medicaid Budget Challenges and Reforms

2009 - 2011	2024-2027
Over reliance on one-time federal money	Over reliance on one-time federal money
Across-the-board provider rate increases	Across-the-board provider rate increases
Payment not tied to quality	Payment not tied to quality
34 inefficient health plan regions	Less efficiency going from 5 plans to 7
Prescription drugs carved out of managed care	Prescription drugs carved out of managed care
No coordination between Medicare and Medicaid	Plan to expand MyCare statewide in 2026
8.9 percent annual growth	**8.9 percent annual growth**

Source: Ohio Governor's Office of Health Transformation (2014).

Slide 22.

Ohio Medicaid Expansion History and Impact

Ohio Joint Medicaid Oversight Committee
March 20, 2025

Greg Moody, former director
Ohio Governor's Office of Health Transformation