MEDICAID EXPANSION IN INDIANA: PUBLIC HEALTH IMPACT

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**Introduction**

Would expanding Medicaid coverage improve the health of low-income, uninsured adults in Indiana? This case study examines the potential public health impact of Medicaid expansion in Indiana, as envisioned by the Patient Protection and Affordable Care Act (PPACA) of 2010. It will include a description of Medicaid structure, the intent of expansion, and Indiana’s position on Medicaid expansion. It will also make suggestions for structural interventions to improve public health in the absence of Medicaid expansion.

**Description of Health Issue**

The State of Indiana must decide whether or not to expand Medicaid coverage to all adults in Indiana with incomes below 138% of the federal poverty level (FPL). Expansion would cover approximately 450,000 people, resulting in 1 in 4 adult Hoosiers on Medicaid, a more than 55% decrease in the number of uninsured in the state. The impact of lack of health insurance coverage on health is significant: From 2005 to 2012, an estimated 2,458 adults in Indiana died due to lack of coverage. In 2009, a study by the Harvard School of Public Health found that adults without health insurance are 40% more likely to die prematurely than are insured adults. Adults without health insurance encounter significant barriers to health care access and frequently delay necessary care; health care access has been identified as an important determinant of health, while being uninsured is the greatest barrier to health care access. The uninsured with cancer die sooner than insured individuals, usually due to delay of diagnosis; uninsured adults with chronic diseases such as diabetes and heart disease typically have much poorer outcomes due to lack of ongoing care. Another Harvard School of Public Health study in 2012 examined the health impact of Medicaid expansion to childless adults in 3 states, 5 years prior to and 5 years following expansion. A 6.1% reduction in adult mortality was found along with increased access to health care and improved self-reported
health status; the reduced mortality was especially pronounced among minorities and the poor.6

Other special populations could also benefit from Medicaid expansion: According to a brief issued by the non-partisan policy and research institute Center on Budget and Policy Priorities (CBPP), Medicaid expansion would reduce states’ long-term costs for care of HIV patients and improve patient outcomes by providing coverage of early treatment. Similarly, uninsured veterans with incomes below 138% FPL (nearly half of all uninsured veterans) and the uninsured Native American population could have their number of uninsured cut by half.7

Health coverage is an important condition to assure the health of the population, which in turn improves involvement in the community and contributions to the economy and political process.5 The social and financial implications of lack of insurance are significant. In 2007, 62.1% of all bankruptcies were due to medical debt.8 Indiana had almost 30,000 bankruptcy filings in 2007 and has one of the highest bankruptcy filing rates in the nation.9 These financial ramifications, coupled with the higher likelihood of poor health status can lead to loss of social capital, loss of involvement in the surrounding community, and loss of the ability to lead a productive life.5 Both the private and public sectors can benefit from improved health coverage of the population: A study commissioned by the Indiana Hospital Association (IHA) found that Medicaid expansion would create over 30,000 new jobs and generate over $2.4 billion in economic activity and $108 million in new tax revenue for the state.10

The Uninsured Population in Indiana

The population of Indiana is 81% white, 6% Hispanic, and 9% black,11 while the uninsured adult population who would be eligible for Medicaid expansion in Indiana is 73% white, 10% Hispanic, and 14% black.12 This illuminates a disparity in the state in terms of who has health coverage now and who would benefit most from Medicaid expansion. Nearly half of the expansion-eligible
population makes less than 50% of FPL. Sixty-two percent work in the agriculture or service industries.\textsuperscript{12} The uninsured are more likely to live in rural areas and to be from working families who make above the current minimum eligibility level for Medicaid.\textsuperscript{13}

The low-income, uninsured population in Indiana is likely to be less healthy than the overall population. Nationally, one-third of childless adults below 133\% FPL have a diagnosed chronic condition, and 1 in 6 reports fair or poor health.\textsuperscript{14} Those in the lowest income group (below 50\% FPL) have significantly higher rates of chronic illness and medical needs.\textsuperscript{15} Indiana ranks poorly compared to other states in measures of health: In 2012, Indiana ranked 44\textsuperscript{th} in smoking rates, 42\textsuperscript{nd} in obesity, and 33\textsuperscript{rd} in rate of diabetes. Indiana’s overall health ranking was 41\textsuperscript{st} out of 50 states.\textsuperscript{16}

**Main Components and Issues of the Organization, Financing, and Delivery of Medicaid**

Medicaid was established to provide health coverage to certain poor categories of the population under the Social Security Act Amendments of 1965.\textsuperscript{17} Prior to the establishment of Medicaid and Medicare, most health regulation fell to the states under the authority of the police powers. Health care for the poor varied greatly by state and was viewed as a local issue in keeping with the ideal of federalism: to avoid a concentration of power at the federal level and to give states autonomy in matters of the health and welfare of its citizens.\textsuperscript{18} Federal authority for the Social Security Act came from the Taxing and Spending Powers, which are given to the federal government by the U.S. Constitution. The passage of the Social Security Act in 1935 created what was then referred to as the ‘welfare state’ which paved the way for federal health assistance programs linked to welfare eligibility, as Medicaid was.\textsuperscript{17} Between 1935 and 1965, expansion of the private employer-sponsored health insurance industry increased the gap between those with and without health coverage, leading to a disparity that persists today and increasing the need for health coverage assistance to low-income citizens.\textsuperscript{18} Health care as a share of all economic activity in the U.S. has grown from 7.2\% in 1970 to
17.9% in 2010, leaving the low-income and uninsured increasingly unable to afford health care.\textsuperscript{19}

Although Medicaid eligibility is no longer directly connected to eligibility for modern-day welfare (now called Temporary Aid for Needy Families, or TANF), it continues to be stigmatized as an entitlement or welfare program for the very poor rather than as a means to provide health insurance coverage for those who do not have access to or cannot afford any other coverage, many of whom are working adults.\textsuperscript{18} Health insurance coverage for Americans is defined within an employer-sponsored, insurance-based system. For some categories of the very poor who do not have access to an employer-sponsored plan, the government (through Medicaid) has assumed the role of payer, taking on the added risk of covering a population with a high rate of chronic illness, delayed preventive care, and poor health status.

Medicaid is an example of a voluntary state-federal partnership created through the authority of the Spending Clause in the U.S. Constitution. Congress can offer incentives for states to create programs using federal funds, but the programs must be voluntary in nature. States have some leeway in the determination of eligibility and benefits as long as they meet a minimum standard.\textsuperscript{20} States may not be coerced or compelled. Funding for Medicaid is both state and federal, with a federal percentage match that varies by state. By design, there is no cap on the federal match amount, encouraging the growth and development of Medicaid programs within each state.\textsuperscript{18} This has resulted in an incremental increase in the size of the Medicaid program over time: Medicaid is a major portion of health care safety net funding, providing health coverage to approximately 17% of Americans.\textsuperscript{18,20} Approximately 1 in 6 Hoosiers – 15% of the state’s population – is covered by Medicaid today.\textsuperscript{2} Indiana currently receives a 66% federal match for Medicaid funds. The remaining portion of Indiana Medicaid costs are paid from the State’s general fund and comprise 13.8% of general fund appropriations for fiscal year 2012-2013.\textsuperscript{21} The State spends 57.8% of Medicaid funds
on acute care, and 39.5% on long-term care. In Indiana, 37.2% of acute care spending in Medicaid goes to managed care organizations (MCO) which are paid to administer Medicaid plans for a specific capitated amount per enrollee.

Authority over Medicaid is shared. At the federal level, the US Department of Health and Human Services (HHS), a cabinet agency of the federal government, has rulemaking authority for matters relating to Medicaid. Within HHS, the Centers for Medicare and Medicaid Services (CMS) administer the program. In Indiana, the Family and Social Services Administration (FSSA) administers Medicaid programs. Within FSSA, five subdivisions administer the various Medicaid programs.

Medicaid Expansion

From the perspective of the current federal administration, “Medicaid created an essential partnership between the Federal Government and the States to provide a basic health care safety net for some of the most vulnerable Americans”. Medicaid in this view is a social program, a logical answer to the problem of poor health status arising from lack of health coverage. The intent of Medicaid expansion is improved access to health care and increased use of preventive services, leading to reduced rates of obesity and chronic disease and an eventual improvement in health status for the uninsured population, as well as reduced uncompensated care resulting in decreased health care costs for states (see logic model Appendix A).

Funding for Medicaid expansion will be 100% subsidized by the federal government from 2014-2016, phasing down to a 90% match by 2020. States will be responsible for 10% of Medicaid expansion funding for 2020 and beyond. Forecasts of the costs of Medicaid expansion have varied. Based on a Milliman study commissioned by Indiana, state Medicaid costs (after the federal subsidy) between 2014-2020 will be $612M without expansion, but $1.7B to $2.6B with expansion.
However, an Urban Institute/Kaiser Family Foundation report on expansion costs estimates that once savings in uncompensated care are accounted for, Indiana will only see a 1.6% increase in total Medicaid spending between 2013-2022, or about $537 million. Interestingly, the IHA study projections were approximately halfway between these two estimates.

Another budgetary concern is the “woodwork effect”, the term used to describe the anticipated increase in Medicaid enrollment of individuals who are eligible under pre-expansion rules and will not qualify for the 100% federal subsidy, just the current 66% match. It is anticipated that the individual insurance mandate in PPACA that penalizes those without health coverage will result in this increase. The woodwork effect could cost the State as much as $600M, involve as many as 100,000 individuals, and is expected to occur whether or not Indiana expands Medicaid.

According to Final Rule 45 CFR Part 145 issued by HHS in February 2013, Medicaid plans offered to the eligible expansion population will also be required to offer “essential health benefits” (EHB) that are the same as those required for plans offered in the private insurance and health insurance exchange markets. Medicaid plans must be benchmarked to a plan that is comparable to one offered by a large employer, a state or federal employee plan, or is specifically approved by HHS. EHBs include inpatient and outpatient hospital services and emergency care, maternity and well-child care, pediatric oral and vision care, preventive services, prescription drugs, rehabilitative services, laboratory services, and behavioral health services including substance abuse treatment.

The Healthy Indiana Plan (HIP)

Among Indiana’s existing Medicaid programs is the Healthy Indiana Plan (HIP), which expanded Medicaid coverage to childless adults in Indiana for the first time beginning in 2008. HIP is a section 1115 Demonstration Waiver: a Medicaid plan that has been given federal approval to offer coverage or services not normally covered under the federal match for Medicaid. Programs
approved and administered under 1115 waivers have flexibility to provide or deny certain benefits normally required under Medicaid. HIP covers uninsured Indiana residents between the ages of 19-64 with incomes of less than 200% of FPL. Participants must lack access to employer-based health insurance and be uninsured for at least 6 months prior to HIP enrollment. The basic structure of the plan includes a $1,100 deductible and a commercial health insurance plan administered by a choice of managed care providers. There is also an Enhanced Services Plan (ESP) for HIP members with chronic illnesses and higher risk conditions. HIP participants receive first-dollar coverage for preventive care services up to $500 per year and an individual health savings account referred to as the Personal Wellness and Responsibility (POWER) account. Deposits to the account come from the State and the participant. Participant contributions are on a sliding scale based on income, and participants must make their required monthly contribution within 60 days or they will be expelled from the plan. This account is the cornerstone of the HIP approach, described as “harnessing the promise of consumerism through member participation to incentivize positive health behaviors and improve health outcomes.”

The theory behind consumerism in health care is one of shared responsibility leading to more cost-effective choices in health care, and aligning with the fiscal values of the state administration.

The federal waiver for HIP requires budget neutrality – the plan must not cause any deficit in the State budget or lead to any new taxes or diversion of tax funds not specified in the plan creation. State funding for HIP costs comes from a combination of cigarette taxes, cost savings initiatives, and diversion of federal funds normally provided to defray the costs of uncompensated care. HIP has maintained budget neutrality as required, although the costs of coverage for childless adults were higher than projected following plan implementation and as a result enrollment of childless adults was halted before the intended cap of 34,000. HIP’s waitlist for childless adults has been in the tens
of thousands for most of the plan’s existence.\textsuperscript{29}

A 2010 evaluation of HIP (commissioned by the State) found improvements in access to health care and use of preventive services, and fewer unmet health needs following HIP enrollment. In addition, inappropriate emergency room (ER) use decreased by 14.8%, and use of lower-cost generic prescription drugs increased. Eighty percent of enrollees received annual preventive care.\textsuperscript{30}

Initially, HIP was approved by the federal government through 2012. In 2011, the State requested a 3-year extension of the HIP program, as well as permission to establish a minimum POWER account contribution of $160 per year for all plan participants regardless of income.\textsuperscript{27} In response, Indiana received a one-year extension from CMS to continue HIP health coverage for the enrolled population until the end of 2013.\textsuperscript{31} CMS did not grant the mandatory minimum POWER account contribution. In February 2013, newly elected Indiana Governor Mike Pence again requested a 3-year extension of HIP through 2016 coupled with the declaration that expansion of Medicaid in Indiana would only occur with HIP as the expansion vehicle. In an accompanying letter to HHS Secretary Sebelius, Governor Pence stated that “greater flexibility [from the federal government] would help states create and manage programs consistent with their local values and overcome the bureaucratic and inefficient nature of traditional Medicaid.”\textsuperscript{32} At the same time, the waiver extension application proposed changes to bring HIP in line with federal requirements for Medicaid expansion including the addition of maternity coverage and elimination of the $500 preventive care limit outside of the plan deductible.\textsuperscript{29} But the question of the POWER accounts remains a barrier for the federal government to approve use of HIP. Cost-sharing for Medicaid programs is strictly limited and legislated through HHS rulemaking. Any approval of mandatory cost-sharing contributions in Indiana could have major implications for Medicaid expansions being considered by other states, due to existing cost-sharing limits in the legislation.
Though Medicaid expansion as described in PPACA legislation was intended to be mandatory, the U.S. Supreme Court decision of June 2012 provided states opposing PPACA with additional leverage in regards to expansion. Indiana was one of 25 states joined in the lawsuit challenging the PPACA, which culminated in *National Federation of Independent Business (NFIB) v. Sebelius*.

One of the specific challenges was to the constitutionality of Medicaid expansion. The majority decision in the Supreme Court found that the PPACA’s Medicaid expansion requirements were coercive and unconstitutional. This made Medicaid expansion optional for states, while allowing them to keep current Medicaid program funding. There is no deadline for a state’s decision. States may opt in to Medicaid expansion and later drop out; however, 100% federal funding will only be available in 2014, 2015, and 2016. But given the refusal of HHS to permit Indiana to mandate individual contributions to POWER accounts, the future of HIP is unclear and the question of whether Indiana will expand Medicaid coverage remains.

**State Administration Perspective – The Argument Against Expansion**

Medicaid waste and fraud is estimated to cost the U.S. about $21 billion per year. This has led some, especially conservatives, to perceive Medicaid as “broken” and incompatible with a fiscally responsible option for health coverage for low-income uninsured adults. Governor Pence advocates a complete restructuring of Medicaid in the form of capitated ‘block grants’ for states to develop their own strategies to address health care needs for residents; a view in keeping with federalism and the conservative ideal of smaller government and individual state sovereignty in matters of health and welfare. The states’ mistrust of federal Medicaid is also a factor. Changes to Medicaid reimbursement in the 1990s were perceived as unfunded mandates because states were given no choice but to accept them in order to keep federal Medicaid funds for programs already in place. In addition, increasing taxes to pay for PPACA initiatives (including Medicaid expansion) is a sticking
point for a governor whose mission statement includes protecting Hoosier taxpayers. Politically, Indiana does not want to endorse any part of the PPACA due to the State’s position on its lack of affordability and the perceived imposition on the State’s “inherent sovereignty”; indeed, one of the stated goals of Governor Pence’s Roadmap for Indiana is to “resist efforts to implement the federal health-care law in Indiana.” An additional concern is job loss. An example provided by Pence is Cook Group’s announcement that it would not expand jobs in Indiana due to the PPACA’s medical device tax. Pence also predicts a projected increase in taxes and insurance premiums in the state due to PPACA implementation. Indeed, the conservative policy research organization National Center for Health Policy (NCHP) analyzed Medicaid expansion in Florida and produced findings directly opposed to the IHA study: that Medicaid expansion would not create jobs, that economic activity would not be likely to increase, and that subsidizing private insurance for low-income individuals would be the most successful strategy for the state. Finally, citing Medicaid as one of largest items on the State’s budget paired with projections of over $2B in increased spending, Governor Pence stated that by expanding Medicaid, the PPACA will “destroy…our economic competitiveness and fiscal solvency.” These statements reflect a problem definition that sidesteps questions of population health and focuses purely on fiscal health.

Indiana Senate Bill 551 (SB551) passed the Indiana Senate in February 2013 and is currently under consideration in the House. One of the provisions in the bill requires FSSA’s Office of Medicaid Policy and Planning (OMPP) to enter into negotiations with HHS for Medicaid block grants. OMPP will also be required to apply to CMS for required Medicaid recipient cost-sharing under SB551. In this bill the ideals of federalism and consumerism are both apparent – and are at odds with the federal strategy and ideals of expansion of coverage. Though opponents fear that the use of block grants could increase disparities in health coverage between states due to the loss in
flexibility compared to the current Medicaid funding structure, Indiana has prioritized state rights and market-driven health care in order to avoid what the Pence administration views as “opening the door for the federal government to legislate, regulate and mandate nearly every aspect of our daily lives under the guise of its taxing power.” This bill highlights the difference in the problem definitions and policy solutions between the state and federal governments and does not specify or address what the public health impact of block grants might be.

Additional Stakeholder Perspectives

Following enactment of the PPACA in 2010, FSSA held stakeholder meetings and conducted surveys with stakeholder groups including health care providers, insurers, and businesses.

Physicians cited concerns about insufficient numbers of providers to meet the increasing need as more Hoosiers get health coverage through Medicaid. The low rate of reimbursement for Medicaid is also a concern – many providers do not accept Medicaid patients as a result. More recently, however, the Indiana Academy of Family Physicians supported expansion, as did the American Medical Association, due to the potential for improved health for those who will be covered.

The IHA supports Medicaid expansion. Hospitals could stand to lose a significant amount of money if Medicaid is not expanded. This is due to changes in Disproportionate Share Hospital (DSH) payments, which are made to hospitals serving higher proportions of Medicaid and uninsured patients. State DSH payments are matched by the federal government up to a pre-determined amount. Indiana receives over $214 million annually in DSH payments, and in 2011 Indiana hospitals reported $2.9 billion in uncompensated care. Federal DSH payments are scheduled to decrease under PPACA due to the anticipated increase in insured patients. If Medicaid coverage is not expanded, hospitals are at risk of bankruptcy as revenue declines and operating margins disappear. To date, this problem has not been directly addressed by HHS. The National Association of Public
Hospitals and Health Systems is encouraging CMS to work with states to find alternatives to partial or no expansion, in order to avoid hospital closures and the resulting loss of health care access, especially for rural populations.42

Insurers and fiscal agents contracting with Indiana Medicaid (Anthem, Managed Health Services, MDWise, HP) would see a significant influx of insured if Medicaid were expanded. Capacity and reimbursement rates are a concern for them, although they would likely also see increased revenue.39 State agencies administering Medicaid will be challenged to increase administrative and information technology capacity to handle eligibility and enrollment for the expansion population, as well as budgeting for the State’s share of funding. This includes FSSA, the Indiana Office of Technology, Indiana Department of Insurance, and Indiana Department of Administration.

Businesses in Indiana are concerned about the effect of Medicaid expansion on taxes and health insurance rates due to the State’s eventual share of the cost of Medicaid expansion. Some businesses could benefit, however, if their employees fall under new Medicaid eligibility rules.41,45

The American Public Health Association has written statements in support of PPACA initiatives.46 Public health advocates in Indiana such as the Indiana Public Health Association, Indiana Rural Health Association, The Arc of Indiana, Cover Indiana, and Hoosiers for a Commonsense Health Plan have also expressed support for expansion.47,48,49,50,51 Public health advocates have a distinct role to play in assuring health care access and developing policy to support state and local efforts for health care access. Public health professionals should be guided by the Institute of Medicine’s 2002 report, which supports a broad effort spearheaded by the federal government with advocates at the state and local level to attain health care coverage for all.52

The perspectives of the uninsured are difficult to assess. There is some evidence that the working poor have a stigmatized view of Medicaid and may resist enrollment.18 Nationally, polls have
indicated general support of Medicaid expansion. In contrast to state projections cited by the governor, IHA found that insured individuals in Indiana could potentially benefit from lowered insurance rates as a result of more insured Hoosiers. Annual health insurance premiums are projected to be $236 lower for individuals and $677 lower for families, due to decreased health care ‘cost shifting’ to insured patients. This may increase general support for expansion. More research is needed on the uninsured perspective.

**Alternative Strategies**

If Indiana does not expand Medicaid, the following are suggested strategies and structural interventions to improve coverage and strengthen the health care safety net for uninsured individuals:

1) Purchase of individual insurance plans on an insurance exchange: PPACA allows for premium tax credits for the purchase of coverage on a health insurance exchange for individuals making 100% or more of FPL. Premiums cannot exceed 2% of family income, and there is a two-thirds reduction in allowable out-of-pocket expenses (deductible, co-payments, co-insurance). A family of four who made 100% of FPL in 2012 ($23,050) would have to pay $461 per year in premiums for coverage. However, the out-of-pocket expense yearly maximum would still be approximately $3,993 (based on the 2012 out-of-pocket maximum of $12,100). Thus the potential amount of out-of-pocket expense incurred could be $4,454, or 19% of the family’s annual income. In addition, adults in Indiana who make less than 100% FPL are not eligible for tax credits because PPACA assumed they would be covered by Medicaid expansion, increasing the already significant affordability barrier to the purchase of coverage for this population.

2) Increase the number of Community Health Centers (CHC): The health care safety net is composed of health care providers who serve the low-income uninsured and underinsured population free or at reduced cost. CHCs receive federal grant funds under Section 330 of the Public Health
Service Act to provide health care to those on Medicare and Medicaid, and to the uninsured on a sliding scale based on ability to pay. CHCs must be in medically underserved areas (MUA). Indiana has 92 counties; only 10 do not have MUAs.\(^{57}\) However, nearly half of the counties in Indiana do not have a CHC.\(^{58}\) There are not enough CHC locations to serve the uninsured population in the absence of Medicaid expansion. The most recent assessment of the health care safety net in Indiana found 25 counties reporting poor access to primary health care for the uninsured.\(^{59}\) Increasing the number of CHCs would be necessary to serve the uninsured population in the absence of Medicaid expansion.

3) Prevention and wellness programs for the uninsured focused on weight loss and tobacco cessation to reduce rates of chronic disease: The return on investment for prevention dollars spent may be a compelling reason for advocacy for state funding – a 2008 study reported $5.60 in savings for every $1 invested in community based disease prevention programs.\(^{60}\) Indiana’s current state health plan (ISHIP) doesn’t target the uninsured as a priority.\(^{61}\) However, two of the six health priorities in ISHIP are healthy weight and tobacco cessation. Seeking funding through grants, policy advocacy, and public/private partnerships to create prevention/wellness programs for the uninsured could reduce uncompensated emergency care and high-cost complications.

Recent developments in Arkansas involve a new Medicaid expansion option – use of the federal Medicaid expansion subsidy to offer low-income citizens coverage on the private insurance market, through the state’s partnership exchange with the federal government.\(^{62}\) HHS has given tentative approval to this proposal and it is being deliberated in the Arkansas legislature. Potential pitfalls include the increased cost of private coverage for both state and federal governments. Benefits include higher reimbursement rates, attractive to stakeholders such as insurers and physicians. This strategy is potentially in line with Indiana’s consumerist ideals and should be investigated by the State as an option.
Conclusion

As seen in studies from other states as well as from within Indiana, Medicaid expansion is a broad structural intervention that has the potential to improve access to health care, decrease health disparities, and ultimately improve overall health status for low-income, uninsured adults. Medicaid’s image has suffered from the stigma of welfare and waste, but the program has also demonstrated flexibility and customizability since its inception and has allowed more vulnerable populations to receive coverage than otherwise would have.\textsuperscript{63} Based on more than one current study, Medicaid expansion can potentially benefit not only the uninsured, but also public health stakeholders and the state economy.

The tension between the organizational principles of the current Indiana administration and the federal administration fundamentally shapes how expansion is viewed and how the problem of the uninsured is defined, as well as the resulting policy solutions. However, as the evidence demonstrates, the public health and economic impacts of expansion of coverage are interconnected. Equal policy space is merited. In the event of a stalemate between Indiana and the federal government on the future of HIP as the Medicaid expansion vehicle, Indiana should look more closely at other conservative states’ negotiated models of Medicaid expansion that come closer to the consumerist ideals of the Indiana administration. Other environmental strategies may exist to increase access to health care and improve the health status of the uninsured, low-income population of Indiana on a limited basis. But Medicaid expansion has the potential for a greater impact on public health.
**Indiana Medicaid Expansion Logic Model**

**Theory:** Expansion of Medicaid to the low-income adult population (<138% FPL) will improve the health of that population and will also result in lower health care costs for the U.S.

**Context:** Over 800,000 uninsured Hoosiers; high rates of chronic disease, obesity and smoking in Indiana; enactment of the Patient Protection and Affordable Care Act; Supreme Court ruling of June 2012; rising health care costs nationally; disparities in health care access for minorities, poor, and rural populations

### Inputs

- **Uninsured**
  - Income information for eligibility

- **State**
  - FSSA oversight
  - 10% funding after 2016
  - Contracts with Managed Care Organizations (MCO)

- **Federal**
  - 100% subsidy first 3 years
  - 90% subsidy after 2016
  - Eligibility, benefit, and enrollment requirements

### Activities

- Participants enroll and access health care services within plan parameters
- Determine eligibility
- Enroll participants
- Administer plans
- Provide IRS data streams for state eligibility determinations

### Outputs

- Increased # of insured Hoosiers
- Participants receive routine preventive care, have decreased number of unnecessary ER visits
- Improved health and lifestyle habits due to increased health care access and education
- Improved management of chronic diseases

### Long Term Outcomes

- Improved health status of participants
- Lower healthcare premiums
- Improved operating margins for hospitals

### Short Term Outcomes

- Lower rates of chronic disease, obesity, smoking
- Decreased early mortality rates
- Hospitals receive more reimbursement, provide less uncompensated care

### Impact

- Improved population health
- Decreased health disparities
- Lower healthcare costs
- Increased economic activity in the state
References


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