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House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING
Topic: Affordable Care Act/Medicaid Expansion Repeal
Jewish Healthcare Foundation – Pittsburgh, PA
March 29, 2017

AGENDA

10:00 a.m. Welcome and Opening Remarks

10:10 a.m. Panel One:
- Leesa Allen, Deputy Secretary for Medical Assistance Programs, Pennsylvania Department of Human Services
- Dr. Loren Robinson, Deputy Secretary for Health Promotion and Disease Prevention, Pennsylvania Department of Health
- Jessica Altman, Chief of Staff, Pennsylvania Insurance Department

11:00 a.m. Panel Two:
- Erika Fricke, Health Policy Director, Allies for Children
- B.J. Leber, President and CEO, Adagio Health
- Susan Friedberg Kalson, CEO, Squirrel Hill Health Center
- Carmen Alexander, Senior Operations Manager, New Voices Pittsburgh

11:50 a.m. Panel Three:
- Cassie Narkevic, Health Insurance Enrollment Counselor, Consumer Health Coalition
- Kristy Trautman, Executive Director, FISA Foundation
- AJ Harper, President, Healthcare Council of Western Pennsylvania

12:20 p.m. Panel Four:
- Christie Hudson, LCSW, Clinical Social Work/Therapist
- Dr. Liz Cuevas, Internist, AGH Internal Medicine-Northside

12:50 p.m. Closing Remarks

Testimony on the Proposed

Affordable Care Act and Medicaid Expansion Repeal

Leesa Allen, Deputy Secretary, Office of Medical Assistance Programs

House Democratic Policy Committee

March 29, 2017

pennsylvania

DEPARTMENT OF HUMAN SERVICES

Good morning Representative Frankel, members of the House Democratic Policy Committee, and staff. Thank you for the opportunity to provide information on behalf of the Department of Human Services (DHS) regarding the implications of the proposal to repeal and replace the Affordable Care Act and specifically what the repeal of the Medicaid expansion means for the commonwealth.

In Pennsylvania, Medicaid and CHIP combined provide coverage to over 2.8 million Pennsylvanians, almost half of whom are children. This represents 22 percent of the commonwealth's population. The Medicaid system in Pennsylvania currently serves:

- 1.2 million children, with over 387,000 under the age offive.
- Over 248,000 seniors, age 65 and older.
- 565,000 individuals receiving outpatient mental health services.
- Over 30,000 individuals with intellectual disabilities and autism so that they may live in their own communities.
- Over 55,000 individuals receive services in a nursing home.

In addition, Medicaid:

- Paid for over 58,000 births in 2015.
- Provides $5 billion in payments to hospitals in the commonwealth, according to the PA Health Care Cost Containment Council. This represents 13 percent of their total revenues.

As a result of the Affordable Care Act, more than 1,100,000 Pennsylvanians have gained health care coverage – over 715,000 through Medicaid expansion and about 410,000 through the Marketplace. The commonwealth's uninsured rate fell from 10.2 percent to 6.4 percent in four

years, the lowest it's ever been. The uninsured rate for children fell to 4.1 percent, also an all-time low.

The ACA gave states the option to expand Medicaid eligibility to individuals 19 to 64 years of age up to 138 percent of the federal poverty level, and in 2015, Governor Wolf expanded Medicaid eligibility for these individuals in the commonwealth. If the expansion funding were no longer available, Pennsylvania would be required to make the very tough decision to either find $2.2 billion to continue coverage with state funding or end coverage for the more than 715,000 newly eligible participants in PA. The Medicaid expansion has had significant positive impacts on Pennsylvania, including:

- 124,000 individuals with a substance use disorder were able to gain access to drug and alcohol services.
- General acute care hospitals saw a $92 million decrease in uncompensated care in year one. This was an 8.6 percent decrease in uncompensated care and was the first decrease since 2001.
- 4,422 more physicians, 601 more dentists, and 444 more certified registered nurse practitioners enrolled in the Medical Assistance program.
- Generating an infusion of over $1.8 billion in direct care health spending into the commonwealth in calendar year 2015 and the addition of 15,500 jobs in Pennsylvania in year one.

The recently proposed House Republicans' American Health Care Act (AHCA) would significantly impede the progress Pennsylvania has made over the past several years. The newly proposed plan modifies Medicaid expansion eligibility and the enhanced federal matching funds associated with the coverage of individuals under the expanded eligibility level. Under the new

plan the state would be forced to make decisions about who to cover, what services will continue to be covered, and the rates that we will be able to pay providers.

Prior to expansion, Pennsylvania provided coverage to 140,000 people through the General Assistance Medical Assistance program. While that program was suspended in favor of more comprehensive coverage offered by Medicaid, it is still a statutory requirement that the state provide this coverage. Without federal dollars to cover the expansion population, the commonwealth would still be legally required to provide coverage at a cost of approximately $645 million annually in state funds.

The new legislation also proposes a per capita cap rate for each of the following five eligibility groups effective federal fiscal year 2020:

- Elderly
- Blind or disabled individuals
- Children
- Low-income adults
- Expansion adults

Unlike current funding, which provides federal matching funds for Medicaid expenditures made on behalf of all of the state's federally approved Medicaid eligibility groups, this proposal would limit federal funding to the capped amount calculated and would provide no additional federal funding for health care costs that exceed the calculated cap. Based upon the most recent data available, Pennsylvania has the 7th highest per capita spending in its Medicaid program and is $2,000 above the national median. This type of funding would make it difficult to provide the same level of care to seniors, persons with disabilities, and other vulnerable populations. States would be forced to make difficult decisions about what service and who they can cover. Initial

DHS estimates show a state cost of $860 million to $1 billion related to the per capita cap proposal. DHS is in the process of completing a more detailed review to refine its estimate.

Pennsylvania continues to evaluate what additional amounts will be included in the per capita calculation. For instance, supplemental payments made to providers, such as hospitals, nursing facilities, and safety net providers may or may not be included within the calculation. These funds provide additional support for Pennsylvania providers.

Another component of the plan includes the health insurance exchange. The nearly $1 billion in tax credits Pennsylvanians used to help pay for health insurance from the federal exchange would be lost and replaced with tax credits that are based on age instead of the current subsidies that are based on need.

Generally, people who are older, lower-income, or live in high-premium areas such as rural Pennsylvania receive larger tax credits under the ACA than they would under the American Health Care Act replacement. Under the proposed AHCA, people who are older will receive the largest tax credits, but the proposal also allows older Pennsylvanians to be charged up to five times more than younger individuals. The $4,000 provided through tax credits will likely not be enough to offset this proposed age tax.

The AHCA would create plans with slimmer benefits and larger out of pocket costs like deductibles, copays, and coinsurance. This would shift the majority of costs to consumers when they try to access care, which would disproportionately impact people who have significant health needs and low- and middle-income individuals who would not be able to afford significant health care bills – something fewer Pennsylvanians struggle with due to the ACA.

The plan also defunds Planned Parenthood, a valuable family planning provider in the commonwealth. When Texas eliminated Planned Parenthood from its family planning program,

researchers found a 27 percent increase in births to women previously on an injectable contraception, and pregnancy-related deaths doubled.

In closing, the elimination of funding for Medicaid expansion would eradicate the gains Pennsylvania has made over the past several years in ensuring improved health outcomes for its most vulnerable citizens. Jobs created as a result of the expansion will be lost, the uninsured rate will rise, uncompensated care rates for hospitals will significantly increase, and most importantly, over 715,000 individuals will lose health care coverage. I encourage your feedback on the information presented and look forward to continuing to partner with the committee and General Assembly. Thank you for the opportunity to provide testimony.

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DEPARTMENT OF HEALTH

Testimony on the Affordable Care Act – House Democratic Policy Committee
Wednesday, March 29, 2017

Good morning, I am Dr. Loren Robinson, the Deputy Secretary for Health Promotion and Disease Prevention with the Pennsylvania Department of Health. I would like to thank Representative Dan Frankel and Chairman Sturla for inviting me here today to speak about the impact a potential repeal of the Affordable Care Act (ACA) would have in our commonwealth.

I am here today not only as a Deputy Secretary for the Department of Health, but as a practicing internist and pediatrician who treats communities covered under the Affordable Care Act.

In my role at the Department of Health, my focus is on preventive health and wellness programs geared toward improving the well-being of Pennsylvanians of all ages. My goal is to advance Pennsylvania as a national leader in public health initiatives, including reducing childhood obesity, and decreasing tobacco use, especially among minors and pregnant women.

Under the ACA, Pennsylvania currently receives more than $22 million in federal support for both state and county and municipal health departments.

Some of the items at risk of defunding by having the ACA repealed would include:

- $3.5 million for vaccinations in our State Health Centers for uninsured and under-insured children and adults;
- $1.3 million for health care-associated infections and infectious disease prevention;
- $4.5 million used for prevention of chronic diseases such as diabetes, heart disease and obesity;
- Funding for breast and cervical cancer screenings for low income, uninsured, under-insured and women living in underserved areas;
- Access to care for the more than 3 million Pennsylvanians who live in rural areas;
- $500,000 annually reserved for detection of infectious diseases like Ebola and Zika, as well as the department's ability to detect and respond to acts of bioterrorism.

There is no way the state of Pennsylvania will be able to recover from the loss of ACA Prevention and Public Health Funds (PPHF), as proposed in recent legislation at the federal level. With the loss of this funding we would lose a third of our staff who responds to and investigates infectious diseases. These are diseases such ase Lyme disease, pertussis, mumps, and even the seasonal flu. Last year, utilizing this funding, the department investigated more than 175,000 cases of possible, probable, and confirmed infectious disease, helping to locate the cause and source, as well as provide immunizations and help get affected residents into treatment.

This funding would also negatively impact our efforts to help prevent the spread of communicable diseases. Last year, Pennsylvania noted approximately 80,000 cases of communicable diseases, including 5,000 cases of HIV and 6,700 cases of Tuberculosis, not including an additional estimated 80,000 cases of Sexually Transmitted Disease.

Loss of the ACA funding would also directly impact the operation of the State Health Lab, who last year alone tested over 3,000 specimens for the Zika Virus, of which more than 200 residents tested positive. Utilizing ACA as well as funding from the Centers for Disease Control and Prevention (CDC) we were able to provide counseling and assist those who had tested positive in limiting further transmission and exposure to others. Additionally, we worked in conjunction with the Department of Environmental Protection to respond to 12 clusters of travel associated cases with on the ground mosquito population assessment and control, as well as community education efforts.

Loss of ACA funding would also place extreme stress and fiscal burden on our health systems. According to an analysis by the Hospital and Healthcare Association of Pennsylvania, a phase-out of Medicaid expansion would result in hospitals seeing an increase in uninsured or under-insured patients, leading to an increase in uncompensated care. This further erosion of fiscal positions is a burden that many hospitals, especially those in rural areas which are already in fiscal dire straits, cannot afford to take on, leading to fewer health care options and emergent care locations for those in rural Pennsylvania. These rural hospitals are failing fiscally every day, and this will place rural Pennsylvania in an extremely dangerous situation, and will have a far greater impact on these Pennsylvanians beyond just losing their insurance.

In 2010, the nation recognized the need for a mandatory funding stream dedicated to improving the nation's public health system. It's been seven years now, and our work has just begun. We cannot cut funding to programs as fundamental as keeping our most vulnerable populations healthy.

In short, a repeal of the Affordable Care Act would have devastating effects on the health of Pennsylvanians. I would like to thank you for your time and I look forward to working together to improve the health of Pennsylvanians. I welcome any questions you may have at this time.

Loren Robinson, MD, MSHP is the Deputy Secretary for Health Promotion and Disease Prevention for the Commonwealth of Pennsylvania. Her focus is on preventive health and wellness programs geared toward improving the well-being of all Pennsylvanians. Prior to joining the Pennsylvania Department of Health, she completed the Robert Wood Johnson Foundation Clinical Scholars Program at the University of Pennsylvania where she also served as a fellow in the Leonard Davis Institute of Health Economics and the Penn Institute for Urban Research. Dr. Robinson received her medical degree from Duke University and completed the Internal Medicine and Pediatrics residency program at UNC Chapel Hill in North Carolina. As both a practicing internist and pediatrician, she cares for patients of all ages. Dr. Robinson's research focuses on interventions to improve social determinants of health and provide sustainable improvements in health outcomes. As one of the top ranking public health officials in the state of Pennsylvania, she has recently spoken on the importance of issues such as Lead Poisoning, Teen Health, Immunizations, and the Zika Virus. Recently, Dr. Robinson accepted the invitation to join the board of the Food Trust, a national nonprofit that works to ensure universal access to affordable, nutritious food and information to make healthy decisions. Originally from Buffalo, NY, Dr. Robinson attended Spelman College in Atlanta, GA where she graduated Summa Cum Laude with a degree in French. Dr. Robinson resides in Philadelphia and enjoys traveling, cooking, mentoring, and running to stay fit in the City of Brotherly Love.

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Statement before the House Democratic Policy Committee

The Effects of an ACA Repeal

Presented by:

Jessica Altman, Chief of Staff

March 29, 2017

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Good morning Chairman Sturla and Members of the House Democratic Policy Committee. My name is Jessica Altman. I am Insurance Commissioner Teresa Miller's Chief of Staff. Thank you for the opportunity to be here today to speak about an issue of such significance to residents of the Commonwealth. Thank you also to Representative Frankel for hosting today's hearing.

I applaud the Committee's efforts to shed light on such an important topic. As we begin to talk about the many impacts repeal and replacement of the Affordable Care Act (ACA) would have on Pennsylvanians, we should first recognize the impact that the ACA itself has had on Pennsylvanians. And, that begins with remembering what our health care system was like prior to the ACA's enactment. Before the ACA, sick people couldn't get health insurance due to a pre-existing condition, or if they were able to pay the expensive cost for the coverage, often their pre-existing condition would not be covered under the policy. Individuals with chronic medical issues or anyone who underwent a costly procedure like a transplant could face annual and lifetime limits that left consumers in financially devastating circumstances. Women would see higher coverage costs than men and perhaps not have contraception or maternity care covered. Other critical services like mental health and substance use disorder treatment services and prescription drugs were often difficult if not impossible to find coverage for. Most importantly, more than 10 percent of Pennsylvanians went uninsured.

Since the ACA's passage, Pennsylvania's uninsured rate has dropped to 6.4 percent – the lowest it's ever been. Over 1.1 million Pennsylvanians have accessed coverage only available because of the ACA, and that coverage is much more comprehensive than before the ACA. 5.4 million Pennsylvanians cannot be denied health insurance coverage due to their pre-existing conditions, 4.5 million Pennsylvanians no longer have to worry about large bills due to annual or lifetime limits on benefits, and 6.1 million Pennsylvanians benefit from access to free preventive care services. Additionally, more than 175,000 Pennsylvanians have been able to access substance use disorder treatment services through their exchange and Medicaid expansion coverage. This is critical as our Commonwealth strives to combat the overwhelming impact of the opioid crisis.

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With all of that being said, the ACA does have room for improvement. Last year, two health insurers left Pennsylvania's exchange and our Department had to approve significant rate increases to ensure consumers in every county in Pennsylvania continued to have access to subsidized coverage through the exchange. We should be talking about how to stabilize this market, how to make sure the market works better for consumers, and how we can ensure this is a market insurers want to continue to offer products in for the long-term. But, that is not the conversation currently happening in DC.

There have been plenty of discussions about replacing the ACA with a variety of different alternatives, and earlier this month, members of the U.S. House of Representatives released the American Health Care Act (AHCA) as their first repeal and replace plan. I would like to offer the Department's thoughts on a few aspects of this proposal.

Removing Minimum Cost-Sharing Standards to Lower Premium Costs

The current proposal intends to address premium costs by removing requirements that insurance companies offer plans with certain levels of cost-sharing. Allowing plans with higher levels of cost-sharing may make coverage less expensive at face value, but it does nothing to address the true issue of rising health care costs. Instead, costs will shift from monthly premiums to out-of-pocket costs like deductibles, copays, and co-insurance that consumers face when the need to access care – something we all need to do at some point. These plans could resemble bronze plans sold today, which have annual deductibles that can reach $7,000 for an individual and $14,000 for families. In addition, it will be harder to compare the likely out-of-pocket expenses under these plans. The law also proposes expanded use of Health Savings Accounts to help with the additional upfront costs. This sounds good, but while it may be good for wealthier individuals, we worry that low and middle-income consumers will not be able to afford putting extra money into an HSA when they need to balance such spending with everyday needs like food, clothing, and shelter. Shifting costs to point-of-care, and making those costs harder to compare when shopping for coverage, will only put more burden on consumers. We are concerned that we will see a return to the pre-ACA world where more people struggle to pay medical bills or opt to go without care because they're driven away by the costs.

Tax Credits in Place of Subsidies

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Under the AHCA, subsidies that help lower monthly premiums and other out-of-pocket costs would be replaced by tax credits based on a person's age. Additional assistance that currently helps lower income Pennsylvanians pay for their out-of-pocket costs like co-pays and deductibles would go away all together. Low and middle-income Pennsylvanians will almost certainly fare worse under this plan because financial assistance will not be varied based on a person's need. When coupled with the shift to out-of-pocket costs, this could render some individuals completely unable to afford care. The GOP proposal also permits an "age tax" that would allow older Pennsylvanians to be charged up to five times what a younger person would pay. Although the tax credit will be highest for seniors, it likely will not be enough to make up for the higher premiums. According to an Insurance Department analysis, a 60 year-old Lancaster County resident earning $20,000 annually would pay $8,654 more for the cheapest silver plan under the GOP proposal *based on current premiums*, up from $816 to $9,380. That is, the AHCA would have this 60-year old paying half of their income on health insurance premiums alone, not even counting out-of-pocket expenses, or the increased premiums due to the "age tax". Individuals in rural areas like Pennsylvania's "T" (lower central Pennsylvania and the northern tier) would also be harder hit by this tax credit proposal since health care costs tend to be higher in rural communities and the AHCA's tax credits would be a fixed amount rather than a percent of premium. For example, a 45 year-old making $30,000 in Columbia County would pay roughly $4,000 under the GOP proposal *based on current premiums*, whereas the same person in Pittsburgh would pay only about $644.

Coverage for Individuals with Significant Health Needs

This proposal also raises concern for individuals with significant health needs. The ACA's "three-legged stool" – the individual mandate, non-discrimination requirements for people with pre-existing conditions, and subsidies and cost-sharing reductions – was designed to help insurers balance the added risk of individuals with pre-existing conditions while avoiding the risk of adverse selection where people only enter the market when they are sick and need care. Under the current proposal, the individual mandate will be replaced by a continuous coverage requirement, which may prompt typically healthy people to delay entering the market until they have a particular need for coverage. And, people that go without insurance for a period of time will face a penalty in the form of a higher premium when they choose to get coverage, which may deter healthy people from getting insurance even when they decide they should. This

means that the people who seek coverage during the open enrollment period will likely be a less healthy population, thus driving up premiums for those who need coverage the most.

Market Stability

The biggest issues the ACA currently faces center around market stability. Between changing market rules from the previous administration, lawsuits over payment of the cost-sharing reductions, relaxed enforcement of Special Enrollment Periods, and outstanding risk corridor payments, there have been decisions made in Washington, both by the Obama administration and by Congress, that have undermined the stability of the individual market. We should be talking about how to address these issues so that the market can work as it was always intended to. Instead, rather than tackling these issues, the AHCA could create even more instability. By getting rid of the individual and employer mandates and replacing it with a surcharge for those who try to get insurance after a period without continuous coverage, there is less incentive for young, healthy people to enter the market. Without low-cost policyholders to balance against the policyholders who require more health care, premiums will only rise for those who remain in the market. Additionally, as currently drafted, there is a gap between when the mandates sunset and when the continuous coverage requirements take effect. It is hard to say what might happen to the market during this period, but we worry that the impact on the risk pool would be significant.

Selling Insurance Across State Lines

While the AHCA does not address cross-state sales, this continues to be a policy proposal on the table in Washington and I would be remiss to not mention the potential negative impacts and risks of such a proposal. There is no question that competition is good, and we need to look for ways to bring more competition to health insurance markets across the country, particularly in rural areas. But, allowing sales across state lines is just not the way to get there.

Allowing states to participate in cross-border sales is already explicitly allowed under the ACA if states pass laws allowing plans approved by other states to be sold in their state without additional regulation. Three states have passed laws to allow for this, and a handful of other states have passed legislation to authorize their state to enter into a compact with neighboring

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states that would facilitate cross-border sales. Interestingly, no insurer has chosen to sell products approved by another state in the states that allow them to and no states have actually entered into the interstate compacts allowed by the ACA.

There are two reasons for this: first, health insurance is inherently local. Health plans today are built around local provider networks, which can take time to build. In building those networks, insurers require market power to negotiate favorable discounts for reimbursement that can result in competitive premiums. Generally, we hear from health insurers that the reason health plans don't often enter new markets is not regulation: it is network construction. Without this local network, plans from other states wouldn't make sense for our consumers because Pennsylvanians don't see doctors in Georgia or Oregon or Hawaii: they see doctors in their own communities. Second, health insurance rates are also geographically specific and reflect how underlying costs vary by region. So, the actuarially accurate price of a plan sold to consumers in Georgia or Oregon or Hawaii wouldn't make sense for a consumer accessing care in Pennsylvania, because the cost of receiving that care can vary greatly.

States also, for very good reasons, have different rules for the plans sold to their residents. For example, Pennsylvania's General Assembly has decided that certain benefits should be guaranteed for many consumers in our Commonwealth, such as mental health and substance use disorder treatment and services for children with autism. If we allow products approved by other states to be sold in Pennsylvania, they may not have these same benefits. Insurers could choose to file plans and sell out of a state with more flexible regulations than those mandated by the General Assembly, and Pennsylvania's consumers could lose access to benefits you have decided they deserve. This undermines our Commonwealth's legislative authority.

Finally, consumer protection is the number one priority of our department and what we strive to provide to consumers each and every day. Consumer protection goes hand in hand with state-based regulation. We protect our consumers through our regulatory authority in licensing and monitoring the solvency of insurance companies and in approving products and the rates at which they will be sold. If a Pennsylvanian has a health plan approved by Georgia or Oregon or Hawaii or any other state, and that health plan isn't doing what they should, Commissioner Miller and the department would have limited ability to intervene or take action against the

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company. So, would we rely on another state to provide that service to our consumers, to your constituents? Because of this dynamic, we fear cross-state sales could result in a "race to the bottom," where plans will be approved by the states with the least stringent and most loosely enforced regulation, and consumers would bear the consequences.

Conclusion

The ACA isn't perfect. Instead of targeting what plans cover or granting tax credits instead of need-based subsidies, we need to talk about common sense changes that can stabilize markets and focus on what consumers want and need, like lower deductibles and protections from surprise health care bills. The CBO score that came out a few weeks ago demonstrates how the AHCA would not achieve these goals, but would instead be a significant step backwards.14 million and eventually 24 million more Americans would be uninsured compared to today. Premiums would initially go up, not down, and eventually only be 10% cheaper than under the ACA, while plans would get significantly less generous in their benefit structures. And, the Center on Budget and Policy Priorities estimates that the AHCA would shift $370 billion back on to state budgets.

Our hope is that Washington keeps the needs of consumers at the forefront of their minds as they continue to deliberate. This is about Americans accessing and affording care that is vital to their health and well-being. We cannot return to a place where people are forced to make a choice between their finances or their health. Again, thank you for allowing me to speak with you today. I would be happy to take any questions that you might have.

Jessica Altman was appointed Chief of Staff for the Pennsylvania Insurance Department by Insurance Commissioner Teresa Miller in June of 2015. In this position, Ms. Altman serves as the top aide to Commissioner Miller, oversees policy initiatives for the agency, and coordinates policy with other state government agencies, and external groups.

Ms. Altman represents the Department in a number of statewide initiatives including coordinating aspects of Health Innovation in Pennsylvania, which leverages funds from CMS's State Innovation Model Initiative, and sitting as a board member for ABC-MAP, the Commonwealth's initiative to implement a prescription drug monitoring program. She is also an active member of the National Association of Insurance Commissioners (NAIC), and is vice-chair of the NAIC's subgroup evaluating the definition of quality improvement activities for the medical loss ratio.

Prior to joining the Pennsylvania Insurance Department, Ms. Altman worked in the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight. Here she developed policy and facilitated implementation of the Affordable Care Act. In addition, she analyzed policy for the Health Division of the White House Office of Management and Budget.

Ms. Altman earned a Master in Public Policy Degree from the Harvard University John F. Kennedy School of Government, and a Bachelor of Science in Policy Analysis and Management, with a concentration in Health Care Policy, from Cornell University.

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Testimony Before Democratic Policy Committee
Pennsylvania House of Representatives
March 29, 2017

My name is Erika Fricke, and I am the health policy director at Allies for Children, a nonpartisan nonprofit that works to serve as a bold voice for policy and practice changes that improve the lives of children and youth in Allegheny County.

Public Health Insurance Impacts

Pennsylvania is in the enviable position of having the highest insured rate for children in our state's history—96.1 percent of children have medical insurance. In Allegheny County, the location of this committee hearing, we exceed that rate. More than 98 percent of children are insured. Our high insurance success rate relies on two essential programs of public health insurance for children—Medicaid and the Children's Health Insurance Program (CHIP). As of last month, 1.2 million children under the age of 21 received health insurance through Medicaid. An additional 172,000 are covered through the Children's Health Insurance Program.[1] A smaller number of children receive insurance through the Marketplace exchanges. These programs supplement employer-based insurance.

The strength of our children's public health insurance program bodes well, because health care coverage, and Medicaid in particular, is a sound investment. The Georgetown University Center for Children and Families (CCF) produced a *Medicaid at Fifty* document, reviewing fifty years of research on Medicaid impacts, including studies tracking children over time. Using longitudinal data starting in the1980s, researchers found long-term impacts from having access to Medicaid early in life: a 26 percentage point decline in the incidence of high blood pressure, and lower rates of hospitalizations and emergency room visits in adulthood.

Children enrolled in Medicaid had lower rates of eating disorders, alcohol abuse and mortality as adolescents. They were less likely to drop out of high school (9.7 percent decline) and more likely to graduate from college (5.5 percent increase), earning higher incomes than their parents and paying more in taxes.[2]

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[1] PA Department of Human Services date from February 2017

[2] Chester, Alisa, and Joan Alker. *Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid.* Georgetown University Health Policy Institute, July 2015. *Georgetown University Health Policy Institute; Center for Children and Families*, ccf.georgetown.edu/wp-content/uploads/2015/08/Medicaid-at-50_final.pdf. Accessed 28 Mar. 2017.

Insurance Program Structures In Pennsylvania

In Pennsylvania, Medicaid covers children living in families with incomes up to 138 percent of poverty, as well as very sick or disabled children. About 43 percent of all Medicaid recipients in the commonwealth are children. Not only does that speak to the importance of the program for children's health, but it also means that any changes to the program have an outsized impact on children.

Families from 138 percent to 319 percent of poverty receive sliding scale subsidies through CHIP. Pennsylvania is one of only a few states that allow families above 319 percent of poverty to purchase CHIP at cost. Pennsylvania's CHIP program provides quality care at a reasonable price. In part, that's because children are relatively inexpensive to cover, compared to adults. But CHIP also benefits from the fact that the pool of children enrolled in CHIP is fairly healthy, overall. Children with serious medical needs are covered through Medicaid. Ultimately, Medicaid in Pennsylvania provides care for both our most vulnerable and our sickest children. The Children's Health Insurance Program (CHIP) plays an important role in coverage, but compared to Medicaid, it covers a much smaller number of children—about one-seventh as many. Those children live in higher income families. The child-specific benefit packages available within CHIP have been found in studies to meet children's unique needs more effectively than plans targeted to adults, including those available via the Marketplace. Additionally, out-of-pocket costs within both CHIP and Medicaid are limited, keeping costs affordable for families.[3]

Medicaid critics claim the program provides less access to care than CHIP. In order to understand the program's current service provision, Allies for Children, in partnership with the Health Law Clinic at The University of Pittsburgh School of Law, recently conducted a secret shopper survey to determine whether or not children in the zip codes determined to have the highest needs, according to the Allegheny County socioeconomic needs index, really did have access to care. We found that regardless of whether or not children had Medicaid or CHIP, children could receive appointments within a week, in about half of cases, and in most cases, within two weeks.

As the program exists, children have access. However, arbitrary caps in Medicaid would mean fewer children eligible for the insurance, children receiving fewer services or lower payments to providers.

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[3] Cardwell, Anita, and Maureen Hensley-Quinn. *State Perspectives on Children's Coverage in the Changing Health Policy Landscape.* National Academy for State Health Policy.

In summary, Medicaid is a robust, effective program that provides key health coverage now and yields important results over time. CHIP is an essential way to extend insurance coverage; ensuring moderate-income families can purchase health care for their children, sometimes with a significant subsidy. Neither program works alone.

Politics of Health Insurance Moving Forward

Unfortunately, in the current political environment, it's hard to gauge how the federal law changes might impact Pennsylvania's ability to continue to offer coverage. Under current law, for each dollar Pennsylvania spends to provide Medicaid coverage for children, the federal government pays half. For CHIP, the federal government pays 89 cents. Since CHIP is a block grant, funding can be depleted. The state is limited in how much it can spend and sets eligibility and benefits accordingly. Medicaid coverage, however, has long been guaranteed for any eligible child.

Recent proposed changes to the Medicaid program would have rescinded that long-standing promise. The National Association of State Medicaid Directors, a bi-partisan organization representing Medicaid directors in all 50 states, stated publicly that proposed Medicaid changes *could expose states to the greatest inter-governmental transfer of financial risk in the country's history.*[4] Should arbitrary caps be put on Medicaid spending, state government, county government and school districts—all of which use federal Medicaid dollars to pay for health services within their jurisdictions—would be forced to implement cuts or raise taxes.

While that legislation is stalled for the time being, the next debate is already set. The Children's Health Insurance Program funding ends in September 2017, while the provisions put in place by the Affordable Care Act that requires states to keep the same eligibility guidelines last until 2019.

Additionally, key elements of the Affordable Care Act, such as Express Lane Eligibility, which makes it easier for states to enroll eligible children and increased matching funds for CHIP, have been essential to the commonwealth's ability to reach historic levels of coverage. Pennsylvania has a proud history of promoting children's health insurance. We claim to be the birthplace of the CHIP, which some histories note started right here in Allegheny County, with a partnership between a local church and a local insurer, providing insurance for children of steelworkers who had lost their jobs, and therefore insurance for

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[4] *Medicaid Structural Reform Proposals & Technical Considerations.* National Association of Medicaid Directors, 14 Dec. 2016, medicaiddirectors.org/wp-content/uploads/2016/12/Technical-Considerations-in-Medicaid-Reform-Proposals_FINAL-1.pdf. Accessed 28 Mar. 2017.

their children.[5] Historically, Pennsylvania has maintained its commitment to ensuring children can get preventive health care they need.

In order to protect our gains, state legislators should encourage congressional leaders representing their districts to honor the federal government's part of the bargain, instead of passing cuts on to states by limiting funds for CHIP or Medicaid. The state can and should ensure easy accessibility to all children by continuing to use technological improvements to enroll children in insurance easily. Finally, state legislators should maintain standards for the health benefits insurance companies are required to provide to children, whether enrolled in Medicaid, CHIP or the private marketplace. The hope is that legislators will not cut pennies from budgets now, and risk creating deficits in the health of our children, later.

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[5] Born, Molly. "Coalition Aiming to Support, Strengthen Children's Palliative Care." *Pittsburgh Post Gazette*, 31 Aug. 2015. *Pittsburgh Post Gazette*, www.post-gazette.com/local/region/2015/08/Coalition-aiming-to-support-strengthen-kids-palliative-care/stories/201508310064?pgpageversion=pgevoke. Accessed 17 Mar. 2017.

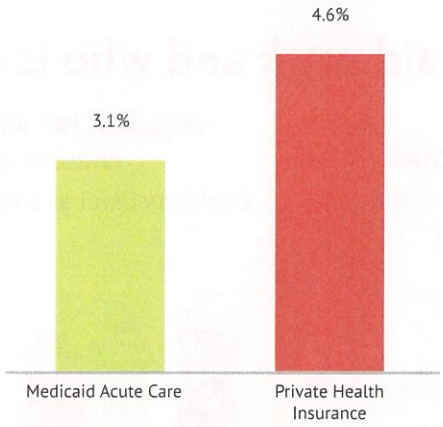
MEDICAID IN PENNSYLVANIA

ALLIES FOR CHILDREN

How are Medicaid funds spent and how is the program financed?

On a per enrollee basis, Medicaid spending growth is slower than private health care spending, in part due to lower provider payments.

Per enrollee spending growth in the US, 2007-2013



61% of total federal funds received by Pennsylvania is for Medicaid

The Henry J. Kaiser Family Foundation, Medicaid in Pennsylvania, January 2017

How does Medicaid benefit children?

Medicaid coverage for children results in:

- **Medicaid coverage for Healthier Adults:** Children with Medicaid had a decline in high blood pressure, lower rates of hospitalizations and emergency room visits, and less instances of eating disorders, drinking and mortality.
- **Greater Academic Achievement:** Children with Medicaid were less likely to drop out of high school (9.7 percent decrease) and more likely to graduate from college (5.5 percent increase).
- **Increased Economic Success.** Children with Medicaid had higher incomes later in life and were more likely to surpass their families' economic status.

Georgetown University Health Policy Institute Center for Children and Families, Medicaid at 50: A Look at the Long-term Benefits of Childhood Medicaid, July 2015

MEDICAID IN PENNSYLVANIA

ALLIES FOR CHILDREN

What is Medicaid?

Medicaid is a joint federal and state program that, together with the Children's Health Insurance Program, provides health coverage to over 72.5 million Americans, 2.9 million of which reside in Pennsylvania, including children, pregnant women, parents, seniors and individuals with disabilities. Medicaid is the single largest source of health coverage in the United States.

Federal law requires states to cover certain groups of individuals.
Citation: Medicaid.gov

How does Medicaid work and who is eligible?

Each Medicaid program is unique:

Federal government sets core requirements, but states have flexibility regarding:

Eligibility- All states have taken up options to expand coverage for children; many have opted to expand coverage for other groups.

Benefits– All states offer optional benefits, including prescription drugs and long-term care in the community

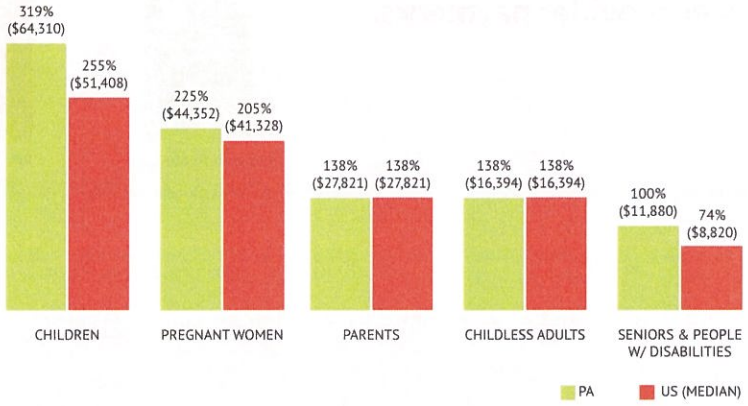
Delivery system & provider payment– States choose what type of delivery system to use and how they will pay providers; many are testing new payment models to better integrate and coordinate care to improve health outcomes.

Long-term care– States have expanded eligibility for people who need long-term care and are increasingly shifting spending away from institutions and towards community-based care

State health priorities– States can use Medicaid to address issues such as the opioid epidemic, HIV, Zika, autism, dementia, environmental health emergencies, etc.

Medicaid/CHIP eligibility levels are highest for children and pregnant women.

Eligibility Level as a Percent of FPL, as of January 1, 2017

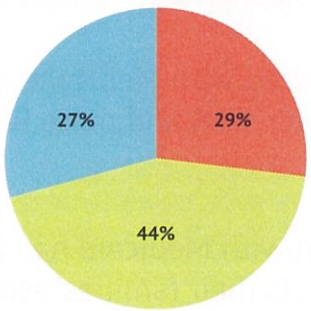


Eligibility levels are based on the FPL for a family of three for children, pregnant women, and parents, and for an individual for childless adults and Seniors & People w/ Disabilities. Seniors & People w/ Disabilities eligibility may include an asset limit.

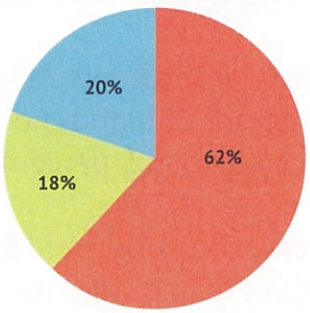
The Henry J. Kaiser Family Foundation, Medicaid in Pennsylvania, January 2017

How are Medicaid funds spent?

Number of Eligible People



Total Expenditures



DISABLED & ELDERLY FAMILIES NEWLY ELIGIBLE UNDER MEDICAID EXPANSION

The Henry J. Kaiser Family Foundation, Medicaid in Pennsylvania, January 2017

WRITTEN TESTIMONY OF BJ LEBER

PRESIDENT & CEO

ADAGIO HEALTH

BEFORE THE HOUSE DEMOCRATIC POLICY COMMITTEE

PITTSBURGH, PA

MARCH 29, 2017

Thank you for the opportunity to give testimony today about the importance of the Affordable Care Act for women of Southwestern Pennsylvania. I would also like to thank Representative Frankel for his commitment to women's health and his leadership as the Chair of the Women's Caucus.

I am BJ Leber, the President & CEO of Adagio Health. For 46 years, Adagio Health has served the women of Western PA, with a focus on those without insurance or other means to access healthcare. We are an important part of the safety net. We are threatened. And as Adagio Health is threatened, so are the 180,000 women in 23 predominantly rural counties who rely on us. We know firsthand that the dismantling of the Affordable Care Act will have a short and long-term impact on women, men, and children in Western Pennsylvania.

Since its inception, the Affordable Care Act has provided an estimated 20 million people with health insurance according to the US Department of Health and Human Services. If repealed, 80% of those losing coverage would be working families many of whom used their insurance to pay for preventative services including birth control or for vital prenatal care.

At our Indiana and Seneca offices, we serve members of the Amish community. In Indiana, Clarion and Edinboro we see students from the universities. In Uniontown, we do our best to serve a community in which so many people have so many unmet needs. In Erie, we give Somali women a safe and welcoming place to receive care. Without Adagio Health, these women- all with different needs, situations and plans for their futures- would have no place to go.

As a country, we have invested almost $9 billion for family planning services for low-income women and men since 1971. This funding, called Title X, supports our contraceptive services, STI testing and treatment, cervical and breast cancer screening and regular health checkups.

For a majority of the women we serve we are the ONLY healthcare provider they see. Our services include breast and cervical cancer screening, access to nutritional food, healthcare referrals, education and breastfeeding support to new moms, prenatal care and outreach on topics such as healthy relationships and substance abuse. The services we provide are life-changing. Studies show a woman with access to quality healthcare and affordable contraception is able, on her own timeline, to complete her education, get and keep a good job, financially support herself and her family and invest in her children's future.

For women of means, access to healthcare is a given. For women who struggle financially, access to our services is life changing, be it a lump detected by a free mammogram or birth control so that pregnancy can be delayed until the timing is right.

Providing these services to those who need them the most- from uninsured to underinsured to abuse victims who need confidential family planning services- creates and sustains healthy communities. Restricting or removing support for women's healthcare – offered by Adagio Health and other similar organizations- has short-term impact on individuals and long-term impact on our economy, our culture, and yes, our children.

I will close with a thank you we received from a patient in Rankin. She told us Adagio Health saved her life. She shared her breast cancer journey that started with a mammogram voucher provided by Adagio Health and funded by the Susan G Komen Foundation. She ended up having a double mastectomy, reconstructive surgery (twice), chemotherapy, and radiation. She stated how well she was treated through the entire process. She couldn't be more grateful. She feels blessed that she was afforded this life-changing opportunity free of cost.

We need to be here to help the next woman like this who needs our services, and each one after her.

BJ Leber
President & CEO
Adagio Health

BJ Leber is the President & CEO of Adagio Health. For 46 years, Adagio Health has served the women of Western PA, with a focus on those in need. 180,000 women per year receive services, which include family planning, nutrition (WIC- Women, Infants and Children and Power Up in-school programming), breast and cervical cancer screening and education. Services are delivered by Adagio Health offices and community partners throughout 23 counties in Western PA. She previously served as President & CEO of The Western Pennsylvania Hospital Foundation and The Forbes Health Foundation, as well as Interim CEO for the YWCA, Chief of Staff for Pittsburgh Mayor Bob O'Connor and VP & Station Manager for WQED Pittsburgh's Public TV and Radio Stations. In 2016 she was appointed by Pennsylvania Governor Tom Wolf to serve as Chair of the Intergovernmental Cooperation Authority. She is member and past president of the Pittsburgh Chapter of the International Women's Forum and serves on the Board of the Family Planning Councils of America, Pittsburgh Community Broadcasting (WESA and WYEP Public Radio Stations), Highmark Caring Foundation.

WRITTEN TESTIMONY OF SUSAN FRIEDBERG KALSON

CEO

SQUIRREL HILL HEALTH CENTER

BEFORE THE HOUSE DEMOCRATIC POLICY COMMITTEE

PITTSBURGH, PA

MARCH 29, 2017

I am here today to speak not only as the CEO of an organization that has flourished through the ACA, but also as a tax payer, a concerned citizen, and most of all, I hope, as a voice for the thousands of patients we serve who don't have the privilege of addressing you today. Every day, our wonderful staff care for these patients, women and men, infants and the elderly, refugees fleeing war across the globe and Pittsburghers born in the houses in which they still reside. We have the privilege of entering their lives, meeting their families, and sharing the grave responsibility of helping them live healthier, more productive lives, regardless of their circumstances.

Squirrel Hill Health Center is a Federally Qualified Health Center or FQHC that provides comprehensive primary and preventive medical, behavioral health and dental services to an underserved population at two fixed locations and one mobile unit in urban Pittsburgh. Our services range from prenatal care through geriatrics, and include integrated behavioral health assessments and therapy, full dental services, extensive care coordination, lab services, insurance assistance, interpretation for non-English speakers, and house calls for the home bound.

Like all FQHCs, we are dedicated to providing the best possible services to everyone in our communities, regardless of insurance status or ability to pay. Like them, we are governed by a patient majority board of directors, and are required to submit extensive, publicly available reports on everything from our demographics to our finances to our health outcomes. Every one of the national network of 1300 FQHCs is supported in part through direct grants from HRSA, an agency of the US Department of Health and Human Services and in part through insurance reimbursements, including a special Medicaid rate that is available only to FQHCs and is set on a cost basis, rather than fee for service. This rate, called the PPS rate, is essential to FQHCs' ability to provide high quality services to large numbers of high risk, vulnerable patients, and makes it possible for FQHCs to be the nation's leading provider of primary care for these populations, in a manner that has positive, documented clinical and financial outcomes.

In 2016, Squirrel Hill Health Center provided 23,247 face-to-face clinical visits to 5,880 individual patients, a growth of 25% over 2015. At least 76% of all patients lived in low income households and 53% were insured through Medicaid. Because of high utilization by Medicaid insured patients, who often have complex medical needs, Medicaid accounted for over 69% of

our insurance reimbursement revenue and was second only to our federal grant as a source of sustaining income for our organization.

In the first two months of 2017, we have maintained this payer mix and have seen nearly 2,600 patients, putting us well on track to exceed our federally mandated goals of continuing our growth trajectory and providing 35,000 visits to 8,300 individuals in 2018. Changes to the ACA or to FQHCs' line item in the Federal budget could reduce up to 70% of our federal funding. These are funds which were originally appropriated for FQHCs through the ACA and are not protected beyond 2017. For SHHC, a return to pre-ACA funding would significantly undermine our ability to continue to care for our existing patients, let alone grow. We could be forced to close our Brentwood site and to eliminate our behavioral health services, both of which were funded through competitive ACA grants. We would have to lay off staff and turn away and estimated 1,500 current patients.

But even if all of our federal funding is re-appropriated, potential changes to Medicaid, including block granting to the states, threaten our viability as well. Any disconnecting of federal involvement and oversight of Medicaid spending could remove the legal protections that ensure our PPS rate, reduce the federal dollars that support expanded access to Medicaid across the nation, and put control of a limited amount of funding in state hands, without ensuring that it be used to care for the most vulnerable patients. Such changes have the potential to reduce our current budget even more drastically than federal funding cuts: if Medicaid were changed, we could lose 40% of our total annual organizational budget.

Such cuts would be devastating to our patients, limiting their ability to get the health care they need to live as productive members of society. Over 3,000 current SHHC patients, among them those struggling with mental illness or addiction, young parents and older workers, could lose the insurance that currently provides them not only with access to our services, but to the specialty services – everything from X rays to colonoscopies, cataract surgery to chemotherapy – that we cannot provide directly. We would lose the single largest source of revenue in our budget, but they would lose the ability to receive treatment for cancer or testing to prevent it. We would struggle to stay open, but they would fight for their lives.

This is not a theoretical proposition. When Medicaid Expansion first rolled out, we discovered that our new patients included those who had waited to seek treatment until they had insurance. In the first weeks after Medicaid expansion, one doctor saw two different patients who had each postponed care until they were in the advanced stages of cancer. In each instance, because those patients now had insurance, we were able to refer them to oncologists for surgery and treatment. Each of those patients is still alive today – but still in need of treatment to stay alive. To put it simply, if Medicaid is rolled back, they will die.

And so will others. I am haunted by the story of a young woman whose family tragedies drove her to addiction. With our behavioral health staff members' insistent support and intervention,

she finally entered in-patient treatment, got clean, and returned to us for ongoing out-patient care. Today she is a productive member of society, working toward self-sufficiency. But without insurance she too could be dead.

Neither Medicaid nor the ACA is a perfect solution to the complex challenge of providing appropriate access to health care for all. Both are mired in bureaucratic entanglements that are difficult for both patients and providers to understand. The lower cost high deductible plans that some have found through the ACA, offer little more than catastrophic coverage; SHHC must still providing sliding fee discounts for primary services to lower income patients on such plans and specialists remain unaffordable. Understanding different options for insurance policies is challenging. And the unpredictability of the Marketplace in the current environment makes planning difficult for both individuals and providers. But overall, seven years in, for FQHCs and for the Pennsylvania residents who entrust us with their care, the ACA has been a resounding success.

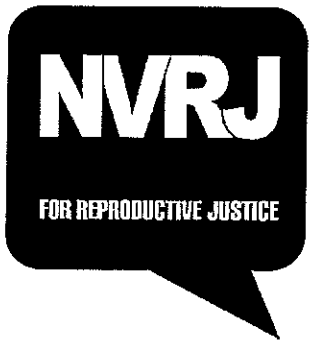
I want to close with a word of warning. We are all painfully aware that opiate overdose is now the leading cause of death in young adults across the nation and that in Pennsylvania our overdose rates are among the highest in the country. Millions, even billions, of dollars are already being poured into efforts to improve treatments and save lives. But most of the patients who will ultimately benefit from improved access to better treatments, including medically assisted treatments such as buprenorphine, which SHHC is about to implement, will only have access to that care – and to primary care -- if they have insurance. And because their lives are ravaged by addiction, they will only have insurance if they have expanded Medicaid. Take away expanded Medicaid and you will remove any hope of throwing the lifeline of treatment to them, in our primary care setting or any other setting. Take away ACA funded resources for treatment, and they will die. Not just a few and not someplace else, but thousands, in this state, in this city, in all of our neighborhoods. Because like all of our patients, they are not some disposable "Other," unworthy of care. They too are us, our neighbors, our colleagues, our friends and our families. And their lives are in our hands.

Thank you.

Susan Friedberg Kalson

CEO, Squirrel Hill Health Center

A lawyer with a background in health law and health consulting, Ms. Kalson has served as CEO of Squirrel Hill Health Center since it opened in 2006. A third generation Pittsburgher with a long history of community involvement, Ms. Kalson oversees all aspects of SHHC operations, including outreach and development, and is available to speak about SHHC with community groups upon request. She serves on a number of local, state, and national boards, including as Vice Chair of the Board of the Pennsylvania Association of Community Health Centers.



PA House Democratic Policy Committee Hearing on the Affordable Care Act
Testimony from Carmen Alexander – March 29, 2017

My name is Carmen Alexander, my address is 5907 Penn Avenue, Suite 340, Pittsburgh PA 15206. I am the Senior Operations Manager for New Voices for Reproductive Justice and I have led our Health Care Access Project since 2014.

I'm speaking for the 75,000 Black women and women of color that we serve in Pennsylvania and for myself myself. I'm here to express my support for the Affordable Care Act (ACA) because it has created access to affordable, high-quality health care to the communities we serve - women and families without the ability to cover the costs of comprehensive health care before the ACA.

New Voices has been instrumental in enrolling Black Women, women of color and the LGBTQ+ people of color in Allegheny County since the inception of the ACA. I have seen firsthand the benefits and relief that our constituents have experienced because of the ACA. For example, prior to the ACA, people of color did not qualify for insurance because health disparities among our communities were treated as "pre-existing conditions," such as diabetes, uterine fibroids, obesity, high-blood pressure, domestic abuse and sexual assault. Today, because of the ACA, Black women and women of color are no longer denied coverage based on their medical history.

I personally have a $12,000 bill because of a fall I had just months prior to getting coverage through my job. I was just recently trying to find mental health services and the wait for a provider is over two weeks. I can't help but wonder what other people go through who do not seek services because of lack of coverage. Should we be in debt due to our health? Should we be sentenced to life of pain and illness because our public policy and our society does not guarantee health care as a basic human right?

The ACA is working for millions of people and it could be improved by expanding access and coverage to millions more. We still have challenges with affordability, access to abortion coverage, and access to health care for our transgender sisters and brothers. Our elected officials and policymakers should be working together to strengthen the ACA in those critical areas.

New Voices is relieved that the new administration's recent effort to take away the ACA failed. Over 23 million people were at risk of losing coverage, many of whom were people of color and LGBTQ+. While the immediate threat to the ACA is over, we must remain vigilant to defend against any attempt to undermine access to and coverage by the ACA.

I implore you to support the ACA and work hard to improve it. It is not good policy to play politics with our health and our bodies. You can see that with the ACA millions who were previously uninsured received the care they needed. If you truly serve the people, I ask you to challenge all efforts to repeal the ACA in the future and not rest until every Black woman, femme and girl has access to high-quality coverage that is affordable and sustainable. Trust Black women in Pennsylvania to know what is best for our complete health and well-being through accessible and affordable health insurance coverage.

The Beatty Building | 5907 Penn Avenue, Suite 340 | Pittsburgh, PA 15206
412.363.4500 (o) | www.newvoicespittsburgh.org | info@newvoicespittsburgh.org

WRITTEN TESTIMONY OF CASSIE NARKEVIC, BSW

CERTIFIED NAVIGATOR

CONSUMER HEALTH COALITION

BEFORE THE HOUSE DEMOCRATIC POLICY COMMITTEE

PITTSBURGH, PA

MARCH 29, 2017

Good morning. I would like to thank the Committee for inviting me to speak this morning, and for specifically reaching out to a Certified Navigator. I'm honored to be here and appreciate the opportunity to represent the consumer voice in this discussion.

My name is Cassie Narkevic. I've been a Certified Navigator since 2014. I work at Consumer Health Coalition, a health advocacy nonprofit on the North Side. Certified Navigators are specially trained and certified through the Center for Medicare and Medicaid Services (CMS) to educate and enroll consumers into Health Insurance Marketplace plans. We also enroll consumers into Medicaid or the Children's Health Insurance Program (CHIP). Navigators are required to remain unbiased and to act in the consumers' best interest. We're not permitted to accept payment from insurance companies. Our assistance is provided at no charge.

I'm here today to provide information and education on the consumer experience with the Affordable Care Act in Pennsylvania and the potential impact of the proposed repeal bill.

I want to tell you about Rita. Before the ACA, she had been uninsured for years, because comprehensive, affordable coverage didn't exist. Her family had tried to purchase private health insurance for her before the ACA, but it was too expensive. Plans they could afford were bare bones plans that wouldn't cover her needs and carried low annual limits that limited Rita's benefits. She truly wanted health coverage but could not get it. Under the Affordable Care Act, I helped her enroll in a comprehensive, affordable plan. This gave her peace of mind and true access to health care services. I have helped hundreds of people like Rita. It is because of people like her that I am testifying today.

Since 2013, Consumer Health Coalition has been the lead grantee of a statewide consortium providing Navigation assistance across Pennsylvania. Our consortium partners are PA Health Access Network, Benefits Data Trust, the Healthcare Council of Pennsylvania, and the Multicultural Resource Center. During the latest Open Enrollment period, November 1, 2016 through January 31, 2017, our consortium achieved the following assistance and enrollment numbers:

General inquiries to our help line: 1,348

Enrollments completed: 3,334

Throughout my testimony, I will provide examples of real consumers that I have assisted. To protect their privacy, I have changed their names.

Impact of ACA on Pennsylvania

Passed into law on March 23, 2010, the Affordable Care Act created new health coverage options for people without access to employer or public health coverage. It created new consumer protections and regulations for the healthcare industry. Nationwide, the ACA has helped over 20 million people gain health coverage.

In 2010, the uninsured rate in Pennsylvania was 12.4%. (Garrett & Gangopadhyaya, 2016) By 2016, the uninsured rate in Pennsylvania had dropped to 6.4%, the 15th lowest in the nation. (Office of Governor Tom Wolf, 2016) In our state, over 1.1 million people have gained coverage thanks to the ACA. A repeal puts their coverage at risk. (Jacobs, 2017)

Consumer protections in the ACA benefit many people, no matter how they get insurance. About 5.5 million Pennsylvanians living with pre-existing conditions can no longer be denied coverage based on their health status. About 4.6 million in our state, including over 1 million children, benefited from the ACA's ban on lifetime coverage limits. The ACA closed the Medicare donut hole, which used to force seniors to temporarily lose payment help for their prescription drugs. Thanks to the ACA, Pennsylvania seniors with Medicare have saved $1.3 billion on prescription costs. These are only some of the many consumer protections and benefits contained in the ACA. (Families USA, 2016)

ACA Financial Assistance

To help make health insurance more affordable, the ACA offers two types of financial assistance to consumers: Advance Payments of the Premium Tax Credit (APTC) and Cost-Sharing Reductions (CSR).

APTC are dynamic, refundable tax credits available to consumers with a household Modified Adjusted Gross Income (MAGI) between 100 – 400% of the Federal Poverty Level, FPL. For a family of four, the range is between $24,300 – 97,200 annually. (Healthcare.gov, 2017) APTC is adjusted based on four factors: age, income, family size, and location (since plan costs vary by geographic area.) The basic idea is that a person should not have to spend more than a certain percentage of their income on their health insurance premium. The tax credit adjusts to ensure that the second lowest cost Silver level plan available to that person would not cost more than their expected contribution. The expected contribution varies based on income, but is never higher than 9.5%. (Center on Budget and Policy Priorities, 2013)

The consumer can choose how to receive their APTC. The vast majority choose to receive the maximum credit available, paid on a monthly basis directly from the federal government to their chosen insurer. This makes their monthly bill lower. I have seen this as the clear most popular choice as a Navigator and often hear people express that they simply cannot afford the monthly payments without these tax credits.

Many consumers tell me that they can only afford their health plan because they receive APTC. According to the most recently available data from CMS, the average monthly premium in Pennsylvania is $533 per month. However, among consumers receiving APTC, the average premium consumers are actually billed is $130 per month. (Centers for Medicare and Medicaid Services, 2017)

Cost-Sharing Reductions (CSR) are discounts on out-of-pocket expenses achieved by lowering the actuarial value of a health plan. They are available to consumers with a household MAGI income

between 100 – 250% FPL. (Healthcare.gov, 2017) CSRs help consumers with the lowest incomes afford to use their health insurance by providing discounted deductibles, copays, and coinsurance. CSRs are only available on Silver level plans. (Healthcare.gov, 2017)

As a Navigator, I often explain this option to people and have found that people are far more likely to select Silver level plans when there are cost-sharing reductions. These might bring down the cost of seeing a PCP from $30 to $5. It can reduce a deductible by thousands of dollars.

At the end of the 2017 Open Enrollment period, 426,059 Pennsylvanians had enrolled into Health Insurance Marketplace plans. Of those enrolled, 80.1% received APTC to lower the cost of their monthly premium, and 54.8%, received CSR to lower their out-of-pocket expenses. The statewide average monthly APTC is $424. (Centers for Medicare and Medicaid Services, 2017)

In my experience as a Navigator, this means that over 80% of Pennsylvania enrollees could not afford to keep their health insurance without at least their current level of APTC, and over 54% likely could not afford to use their health insurance or might elect not to buy the coverage without the lower out-of-pocket costs due to CSR.

Barriers to Obtaining Coverage

Even with the current level of financial assistance, some consumers still cannot afford to purchase insurance. Consumers who are eligible for APTC still may not be able to afford the additional monthly expense, when they are facing other debt or financial responsibilities.

I assisted a consumer —I'll call her Sarah -- whose income is slightly over the limit to qualify for Medicaid Expansion. On the Marketplace, Sarah could purchase a Silver plan for about $59 per month, with the highest level of Cost-Sharing Reductions. She takes multiple medications and has been hospitalized several times in past years. However, she felt she could not afford even a $100 deductible. Since Sarah receives SSDI, she was able to qualify for the Medical Assistance for Workers with Disabilities program, so luckily she was still able to get insurance. The stringent eligibility requirements mean that most people who cannot afford private coverage are not eligible for this program.

Consumer Concerns about the ACA repeal bill

I want to share some consumer phone calls I received after this repeal bill was introduced. Consumers are worried about the future of their health insurance, and it's important for their voices to be heard.

Rashad called me, frantic. He had been watching the news talking about the ACA repeal bill. He has a heart condition, and before the ACA, one of his medications cost $500 per month. He asked me if the ACA had been repealed. He said, "I have a cardiologist appointment in two weeks. Am I going to have insurance?"

I got a call from Debbie, who had cancer last year. Thanks to her ACA tax credit and Cost-Sharing Reductions, she got the treatment she needed at a price she could afford. She's scared because the repeal bill would lower her tax credit and eliminate Cost-Sharing Reductions. She takes a medication to prevent a relapse, but wonders if she will be able to afford it in the future.

I heard from a consumer who is a legal immigrant from a majority Muslim country. He is concerned that enrolling in health insurance and accepting a tax credit, which he is legally eligible for, could make him a target. He hopes to stay in the United States permanently, but now he worries that may not be possible. His concern doesn't stem from the repeal bill, but it could affect his health if he decides to cancel his enrollment and then needs care.

How the Repeal bill would affect PA if it were passed

On March 6, 2017, Congressional Republicans introduced legislation called the American Health Care Act (H.R. 1628) (House Republicans, 2017), which intends to repeal or replace a number of key ACA passages through the budget reconciliation process. This process can only address pieces of the ACA which impact the federal budget, so at this time the repeal does not include the many popular ACA consumer protections.

Like every bill, the American Health Care Act would benefit some consumers, but it would do much more harm to consumers. The people who would be harmed the most are older Americans who live in areas where health insurance is more expensive.

Cost-Sharing Reductions

The bill completely repeals Cost-Sharing Reductions, discounts on out-of-pocket expenses that help consumers with the lowest incomes afford to use their health insurance. This repeal would go into effect on January 1, 2020. (Kaiser Family Foundation, 2017) As I described above, in my experience as a Navigator, most consumers receiving CSR could not afford to actually use their health insurance without these savings. They might not feel it's worth even buying health insurance without these savings. A sentiment people often express is "Why do I have to pay so much for health insurance and then I have to still pay so much more to actually use it?"

Repealing CSR will cause consumers to see their deductibles increase by thousands of dollars. As a Navigator, I have seen CSR reduce a consumer's deductible from $3,250 to $100. I have worked with consumers who cannot afford a $100 deductible, but a $100 bill will not bankrupt them in the way that a higher deductible could. By repealing Cost-Sharing-Reductions, the American Health Care Act keeps healthcare out of reach for these consumers.

Consumer example – Russell

Russell is a 54-year-old man in Allegheny County. His income is $20k annually, but his job doesn't offer health coverage. He takes cholesterol medication and needs to have access to a doctor and blood work. Without treatment and monitoring, he could be at risk for a heart attack or stroke.

He enrolled into a Silver level Marketplace plan. He receives APTC of $3,660 per year. His premium is $83 per month, or $996 per year. Due to his low income, he is eligible for CSR. His deductible is reduced to $1,000. A visit to his specialist is only $25. An emergency room visit costs $150.

The proposed bill would slightly decrease his tax credit, to $3,500 per year. His premium would increase to $96 per month or $1,152 per year. The major effect for Russell will be the loss of CSR. His deductible would increase to $3,250. His specialist visit would cost $70. An emergency room visit would cost $750.

The loss of Cost-Sharing Reductions would significantly affect his ability to use his health insurance. Living on a gross monthly income of only about $1,667 per month, he needs to keep his costs down. If he did think he was having a heart attack or stroke, any reasonable person would urge him to go to the emergency room. With his current plan, he would owe a copay of $150 per ER visit. That's already a hardship. If his ER copay rose to $750 per visit, that would be nearly half of his gross monthly income. Under these circumstances, he may second guess himself and avoid going to the ER right away, putting himself at greater risk.

Changes to Tax Credits

As I described above, the ACA issues refundable tax credits that consumers can use to lower the cost of their monthly premium.

The American Health Care Act repeals these dynamic tax credits. It replaces them with stagnant tax credits that adjust only based on age. Consumers would receive a set amount of credit depending on their age range. (Kaiser Family Foundation, 2017) Experts say these credits are significantly lower than the ACA provides, and the credits would be insufficient to purchase insurance. An analysis by the Center for Budget and Policy Priorities found that in Pennsylvania, the average increase of total plan costs for current Marketplace consumers in 2020 would be almost $4,000. Taking into account a change made to the bill on March 20, 2017, the report found that average increases in Pennsylvania would still be about $3,000 per consumer. The analysis incorporated expected increases in both premiums after the tax credit and out-of-pocket expenses like deductibles. (Aron-Dine & Straw, 2017)

The updated version of the bill includes a provision that would allow consumers to deduct healthcare expenses from their taxes if the expenses exceed 5.8% of their annual income. An analysis by Families USA found that this provision would not help most consumers. The primary reason is that consumers would still have to pay much higher premium and out-of-pocket costs throughout the year. The increased cost is expected to cause millions of consumers to drop insurance because it will be unaffordable.

As I have heard from people in my experience as a Navigator, if they cannot afford to purchase health insurance, they will not buy it. Being able to deduct that cost on their taxes is not helpful if they can't pay for it in the first place. The updated version of the bill did not include any provisions to reduce out-of-pocket costs like deductibles, which are expected to rise substantially. (Families USA, 2017)

Under this bill, some consumers who currently do not qualify for an ACA tax credit would receive a tax credit. Some moderate-income young people do not qualify for an ACA tax credit because the cost of a Silver level health plan in their location is relatively low and is considered affordable. The repeal bill's age-based tax credits would be available to them. These people may benefit from the changes. However, the bill is expected to hurt older, low-income consumers the most. (Quealy & Sanger-Katz, 2017)

Using the Kaiser Family Foundation tax credit estimation tool, anyone can make an apples to apples comparison between current levels of ACA tax credits to tax credits issued under this new bill. (Kaiser Family Foundation, 2017) Here is an example:

Allegheny County

Under the ACA, a 60-year-old adult with an annual income of $20k currently receives APTC of $6,120 per year. The consumer would pay only $960 per year in premiums. The consumer would receive CSR, lowering their deductible to $100.

Under the proposed bill, the same 60-year-old adult would receive a flat tax credit of $4,000 per year. Their premium contribution would be 28% of their annual income. After the tax credit, their premium contribution would be lowered to $5,510. After the tax credit, the consumer would still experience a premium increase of 475%. The consumer would not receive CSR, because the bill repeals these savings. The consumer would be responsible for a deductible of $3,250.

Montgomery County

Under the ACA, a 60-year-old adult with an annual income of $20k currently receives APTC of $11,600 per year. After applying the APTC, the consumer would pay only $960 per year in premiums. The consumer would receive CSR, lowering their deductible to $1,000. The deductible only applies to some services.

Under the proposed bill, the same 60-year-old adult would receive a flat tax credit of $4,000 per year. Their premium contribution would be 64% of their annual income. After the tax credit, their premium contribution would be lowered to $12,860. After the tax credit, the consumer would still experience a premium increase of 1,243%. The consumer would not receive CSR, because the bill repeals these savings. The consumer would be responsible for a deductible of $2,500. All out-of-pocket expenses would increase, as well.

This drastic increase in premium and out-of-pocket expenses would force many consumers to drop coverage simply because they could not afford the cost. The nonpartisan Congressional Budget Office (CBO) estimates that under the American Health Care Act, 14 million people would lose coverage by 2018 alone. By 2026, 24 million people would lose coverage. (Congressional Budget Office, 2017)

Consumer example: Rita

I want to draw your attention back to Rita, who I mentioned at the beginning.

Rita is a 75-year-old woman living in Allegheny County. She is a permanent resident who is not eligible for Medicare. Her income of about $13k is over the limit to qualify for Medicaid for someone over age 65. At the end of the latest Open Enrollment period, 2,634 Pennsylvanians over age 65 had enrolled in Marketplace plans. (Centers for Medicare and Medicaid Services, 2017)

Rita had been uninsured for years before the ACA made it possible to find comprehensive, affordable coverage. She receives APTC of $6,372 per year. She enrolled in a Silver level plan with a premium of only $14 per month or $168 per year. Due to her low income, she is eligible for the highest level of CSR. Her deductible is only $100, and a visit to her specialist is only $15.

The proposed repeal bill would reduce Rita's tax credit to $4,000, raising her premium cost to $2,544 per year. The bill eliminates all CSR. Rita's deductible would increase to $3,250 per year. Her specialist visit would cost $75.

These increases would be financially devastating for Rita. She cannot afford to spend over $2,000 on her premium alone. If she were hospitalized, she could not afford a $3,250 deductible. If this bill were passed, Rita would not be able to afford to pay for health coverage. Perhaps her family could help her financially, but a mother doesn't want to rely on her children to support her, and many other seniors do not have that option.

Use of Proposed New Tax Credits

From my perspective as a Navigator, the proposed rules about use of tax credits raise concerns about ease of consumer choice. The ACA created the Health Insurance Marketplace, the online state exchanges where consumers can easily view, compare, and enroll in a health plan.

The proposed bill would allow consumers to use their healthcare tax credits on both Marketplace and off-Marketplace plans, as long as the plan meets the standard of a Qualified Health Plan.

As a Navigator who is required to consider the consumer's best interest, I am concerned that this change will make it difficult for consumers to compare all the plans available to them with their tax credit. Many consumers who come to a Navigator for assistance aren't familiar with health insurance, and/or aren't familiar with computers. If these consumers then had to visit multiple websites to search for health plan options, it would be confusing and difficult.

Even with the current streamlined Marketplace, consumers contact us every year because they went to a fake Marketplace website and were duped into buying a non-Marketplace policy. There is no reason to add more steps to the enrollment process.

Actuarial value ratings

The ACA requires Qualified Health Plans, such as those sold on the Marketplace, to have an actuarial value of at least 60%, meaning the insurer covers at least 60% of healthcare costs. Marketplace plans are divided among five levels: Bronze, covering 60%; Silver, covering at least 70; Gold, covering 80%; and Platinum, covering 90%.

In Pennsylvania, 81% of Marketplace enrollees are enrolled at the Silver level. (This is also true nationwide.) These consumers' plans cover at least 70% of their healthcare costs. Consumers who are eligible for Cost-Sharing Reductions and enroll at the Silver level (54.8% of all Pennsylvania enrollees) see the actuarial value of their Silver plans increased to lower their out-of-pocket costs. Depending on income, a Silver plan for these consumers covers between 73 – 94% of their healthcare costs. (Centers for Medicare and Medicaid Services, 2017)

The American Health Care Act eliminates the actuarial value requirement. Under this provision, insurers could offer plans that cover less than 60% of healthcare costs. It eliminates the ACA requirement for plans to be offered at Bronze, Silver, Gold, or Platinum levels. An analysis by Health Affairs states this could make it difficult for consumers to compare plans. (Jost, 2017)

From my perspective as a Navigator, this does not only harm consumers by providing them with less coverage. Currently, the Marketplace makes it very easy to compare similar plans from different

companies, side-by-side. A consumer can easily decide, for example, to compare all available plans on the Silver level. The consumer knows they are viewing plans that will cover at least 70% of their healthcare costs. They know this is an apples-to-apples comparison. If plans suddenly didn't adhere to uniform coverage categories, it would become extremely difficult for consumers to compare their plan options. They would not know for certain if they were comparing similar coverage levels.

Repeal of revenue-generating measures

The ACA includes a slew of measures designed to raise revenue to pay for the law's expenditures. These include taxes on health insurers and pharmaceutical manufacturers, an increase in the Medicare payroll tax for high-income taxpayers (income over $200k annually for an individual), and tax penalties associated with the individual and employer mandate.

These new measures were intended to essentially pay for ACA subsidies, so the ACA would not add to the federal deficit or take funding from other programs, like Social Security. (Ydstie, 2013) The original CBO score for the ACA estimated it would reduce the federal deficit by $143 billion during the period 2010 – 2022. (Congressional Budget Office, 2010) After the U.S. Supreme Court ruled that Medicaid Expansion was optional, not mandatory, for states, the CBO issued an updated cost estimate in 2012. At that time they estimated the ACA would reduce the federal deficit by $83 billion during the same time period. (Congressional Budget Office, 2012) Those predictions have been accurate. These savings were achieved while increasing the nonelderly *insured* rate nationwide to 89.7%. (Jackson, 2017)

The proposed American Health Care Act would repeal all of these revenue-generating measures. It has been described by public policy experts as a tax cut for the wealthy. An analysis found that the repeal of these taxes will cost $593.7 billion over the next 10 years. (Jost, 2017) The CBO estimate shows that the bill saves money by drastically cutting Medicaid funding and ACA tax credits. The bill trades tax revenue from the highest earning taxpayers for giant losses of coverage among low-moderate earning individuals.

If the AHCA were passed, they expect 52 million people to be uninsured by 2026. (Congressional Budget Office, 2017)

In Pennsylvania, 1.1 million consumers could lose coverage. (Jacobs, 2017)

Age rating

The ACA restricts insurance plan age rating to a 3:1 ratio. An insurer cannot charge the oldest person on a health plan more than 3x the price charged to the youngest person on the plan. Insurance costs typically rise with age, so this rating keeps prices balanced for older folks. (Blumberg & Buettgens, 2013) The individual mandate, which requires younger, healthier people to enroll in insurance or face a tax penalty, helps to balance the risk pool and "make up" for the age rating restriction. (Eibner & Saltzman, 2015)

The American Health Care Act increases the age rating to a 5:1 ratio, allowing insurers to charge older folks up to 5x the price charged to a younger person for the same plan. It permits states to set higher or

ratio if desired. Several reports, including the official scorecard from the nonpartisan Congressional Budget Office, state that this change will drastically increase the price of health insurance for people age 50 – 64. (Congressional Budget Office, 2017) As costs rise, older consumers could be forced to drop health coverage altogether. (Kliff, 2017)

Continuous coverage incentive

The American Health Care Act eliminates the tax penalty for people who remain uninsured. Experts expect some people, mostly young and healthy consumers who think they don't need insurance, to drop coverage if the penalty is eliminated.

Instead of penalizing people who choose not to enroll, this bill proposes to penalize consumers who choose to enroll. At the time of enrollment, consumers would be subject to a 12-month coverage review. If they were without health coverage for more than 63 days in the prior 12-month period, the consumer will be charged a 30% penalty that gets added to their premium for a year. This penalty is paid to the insurance company, not to the IRS, as the individual mandate penalty is paid. (Kaiser Family Foundation, 2017)

Rather than encouraging uninsured consumers to enroll, experts expect this penalty to discourage healthy uninsured consumers from seeking coverage. (Congressional Budget Office, 2017) Coverage gaps most often occur when a consumer faces financial difficulties, such as a drop in income. This penalty only adds to that challenge. (Hagan, 2017)

The penalty shifts from people who are uninsured onto people who get insurance.

Conclusion

Since its passage in 2010, the Affordable Care Act has helped over 20 million Americans gain health coverage, including 1.1 million Pennsylvania residents. Many of these consumers had been locked out of health coverage in the past, often due to burdensome cost or discrimination against pre-existing conditions.

As a Navigator, I have seen firsthand how the ACA helps people every day. I remember Trish, who didn't think she could afford to purchase health coverage, but came in to apply for her children. Trish had a lump on her neck, but without insurance, she couldn't afford to get it checked out. An ACA tax credit helped Trish afford a health plan. Luckily, Trish only had a benign cyst. She still cried over the phone, relaying her story. She was so relieved to have an answer.

Since the introduction of the proposed American Health Care Act, I have heard from consumers are scared about the future of their healthcare. After comparing the bill to the current law, and reading expert analysis, it seems clear that the proposed bill would hurt low-moderate income families like the ones I work with every day. For people most in need of financial assistance, the proposed tax credits are not as generous as the ACA. Eliminating Cost-Sharing Reductions will cause out-of-pocket costs to skyrocket. Other changes, like increasing age rating, will specifically target older people who may be more in need of care.

It's my job to represent the consumer voice. By sharing consumer stories today and a description of this bill's potential impact on Pennsylvania Marketplace enrollees, I hope I've helped you learn more about the consumer experience.

Thank you for your time today.

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Biography

Cassie Narkevic has been a Certified Navigator with Consumer Health Coalition since 2014. She performs education and outreach around issues related to the Affordable Care Act and provides enrollment assistance for the Health Insurance Marketplace, Medicaid, and the Children's Health Insurance Program. She has over 8 years' experience in outreach and education and previously worked in public health research for the University of Pittsburgh and the RAND Corporation. She earned a Bachelor of Social Work degree from Chatham College for Women, where her senior research tutorial explored inadequacies of Pennsylvania's indigent defense system.

WRITTEN TESTIMONY OF KRISTY TRAUTMANN

EXECUTIVE DIRECTOR

FISA FOUNDATION

BEFORE THE HOUSE DEMOCRATIC POLICY COMMITTEE

PITTSBURGH, PA

MARCH 29, 2017

My name is Kristy Trautmann and I serve as executive director of FISA Foundation, a charitable grantmaking foundation in Pittsburgh dedicated to improving the lives of women, girls and people with disabilities in a ten-county area of southwestern Pennsylvania.

Thank you for the invitation to provide testimony. My remarks will focus on the impact of potential changes to the Affordable Care Act and Medicaid could impact the more than 1.7 million people with disabilities who live in Pennsylvania.[1]

The Disability Rights Network of Pennsylvania and numerous other advocacy groups agree that "the Affordable Care Act has been the most significant law to promote health and well-being of people with disabilities since the Americans with Disabilities Act."

The ACA has clearly improved access to care for people with disabilities and chronic conditions and helped them live healthy and independent lives. The ACA has improved access to essential services. Before the ACA, health plans and Medicaid programs often limited necessary services for people with disabilities or simply did not cover them (for example hearing aids or speech therapy for children). Increased access to mental health and substance use treatment and broader access to prescription medications has been life altering for innumerable individuals and families.[2] Without these services, many would risk isolation, suicide, homelessness, incarceration, or premature death. A group of grassroots activists recently started a campaign called "Without the ACA #IWillDie"[3] where they share their stories about the life saving treatments that they would otherwise not be able to afford. Each year many of the 1.5 million Americans with disabilities find themselves stuck in a required two year waiting period before they can become eligible for Medicare due to their disability, and through the marketplace and Medicaid expansion many of them now have a low-cost option for health coverage. ACA also strengthens care coordination between Medicare and Medicaid.[4]

In addition to improving healthcare and access to important services for people with disabilities, the ACA has also removed barriers to employment. Before the ACA, many people with disabilities or preexisting health conditions could not get health insurance through their

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[1] www.Disabilitystatistics.org. Prevalence (2015) using the American Community Survey.

[2] [2] Excerpted from National Health Law Program factsheet: Ten Ways the Affordable Care Act Helps Older Adults and People with Disabilities. file:///C:/Users/user/Downloads/TenWaysACAHelpsOlderAdults.pdf

[3] https://twitter.com/iwilldieproject

[4] Excerpted from National Health Law Program factsheet: Ten Ways the Affordable Care Act Helps Older Adults and People with Disabilities. file:///C:/Users/user/Downloads/TenWaysACAHelpsOlderAdults.pdf

employer and could not afford to purchase it individually. Many had no healthcare options except for Medicaid and were thus forced to choose chronic unemployment[5] or underemployment to be poor enough to be eligible for safety net services because they cannot do without prescription drugs, personal care assistance or medical equipment. Per a recent article in The American Journal of Public Health, in states that have opted into Medicaid expansion, more people with disabilities can work and earn higher wages which reduces the need for other cash benefits.[6] In addition, the provision allowing young adults to remain on their parents' insurance until age 26 provides more time and flexibility for pursuing education and job training opportunities.

Next, I'd like to talk specifically about Medicaid. In PA, People with disabilities account for 25% of Medicaid enrollment but 50% of program spending[7] so block grants and per capita limits will disproportionately affect individuals with disabilities.

Medicaid covers services for people with the most complex needs. Nonelderly adults with disabilities on Medicaid are four times as likely to receive nursing or other health care at home, more than 2.5 times as likely to have three or more functional limitations, and more than 1.5 times as likely to have 10 or more health care visits in a year compared to people with disabilities who are privately insured.[8]

Medicaid provides long-term care services that support people with disabilities' ability to live independently and safely in the community. These include personal and attendant care services that assist people with disabilities with the tasks necessary for daily living, such as eating, bathing, dressing, preparing meals, and going grocery shopping. Medicaid also covers habilitative services that help people with disabilities learn independent living skills; assistive technology, such as lifts, wheelchairs, and speech-generating devices; supportive housing services that help people with disabilities obtain and retain community housing; and community-based mental health services, which help people with mental illness remain out of institutions.[9] Many of these services are unavailable through private insurance, and they are too costly for people to afford out-of-pocket.[10]

By paying for these services, Medicaid plays a key role in helping states meet their obligations under the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision, which require services to be provided in the community rather than institutions, whenever possible.[11]

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[5] http://www.reuters.com/article/us-health-medicaid-disabled-jobs-idUSKBN14F13K, refers to: Effect of Medicaid Expansion on Workforce Participation for People with Disabilities. JP Hall, et al. American Journal of Public Health: http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2016.303543?journalCode=ajph&

[6] Ibid

[7] Estimates of the Kaiser Commission on Medicaid and the Uninsured and Urban Institute

[8] Kaiser Family Foundation. Medicaid Restructuring Under the American Health Care Act and Nonelderly Adults with Disabilities" March 16, 2017. *http://kff.org/medicaid/issue-brief/medicaid-restructuring-under-the-american-health-care-act-and-nonelderly-adults-with-disabilities/*

[9] Ibid.

[10] Ibid.

[11] Ibid.

Federal discussions to block grant Medicaid or to cap utilization rates would shift the financial burden to states. In that case, it will be up to Pennsylvania legislators to manage the budget implications, and it is likely that cost-reduction strategies will be discussed, including narrowing the list of allowable services, increasing premiums or other ways of shifting the costs to individuals or family members. However, more than half of nonelderly Medicaid adults with disabilities live below the federal poverty level, and most, nearly 85%, have incomes below 200% of poverty ($24,120/year for an individual in 2017).[12] Reductions in Medicaid coverage will weaken community-based services supports for people with disabilities, dramatically increase waiting lists, require even more support from already stretched family members, pulling some of them out of the workforce, and will force many individuals who can live in and contribute to the community back into institutional settings such as nursing homes.

Medicaid also funds services for children with disabilities in schools. Children under age 21 are required to receive Early and Periodic Screening, Diagnostic, and Treatment services, or EPSDT, which pays for screenings and treatment for medical, mental health, dental, vision, and hearing problems. Many of these services are not covered or limited under private insurance.[13] Many schools receive funding through Medicaid to provide speech therapy, hearing and vision screenings, behavioral health treatment, personal care and aide services to students with disabilities.

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While my remarks have intentionally focused on the impact of health care reform on individuals with disabilities, I would be remiss if I did not mention that the ACA and Medicaid expansion have also been important in helping women be healthier and safer. Others have offered testimony about basic health services, including family planning, contraception, and maternity care. I would like to offer specific comments on the importance of the ACA and Medicaid to victims of domestic violence.[14] I have worked on the issue of violence against women for nearly thirty years and know that physicians can play an important role in screening women and in supporting victims of abuse to take steps to be safer. However, it has been incredibly difficult to get physicians to ask effective screening questions. For the first time, the ACA mandated reimbursement for domestic violence screening and brief counseling as a billable service, providing a financial incentive to healthcare providers to address these issues.

Before the ACA, state insurance laws allowed[15] insurance companies to charge victims of domestic violence *more* for the same benefit package—or even deny them coverage outright[16] because they had experienced abuse. Prior to the ACA, only 22 states had limited protections

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[12] Kaiser Family Foundation. Medicaid Restructuring Under the American Health Care Act and Nonelderly Adults with Disabilities" March 16, 2017. *http://kff.org/medicaid/issue-brief/medicaid-restructuring-under-the-american-health-care-act-and-nonelderly-adults-with-disabilities/*

[13] Health Services in Schools: Medicaid and Special Education Services. file:///C:/Users/user/Downloads/IDEA%20one%20pager.Final.pdf

[14] Futures Without Violence. https://www.futureswithoutviolence.org/3-things-at-stake-aca/

[15] http://www.americanbar.org/content/dam/aba/administrative/domestic_violence1/writing_competition_winners_cdsv/Stop%20ReVictimizing%20the%20Victims%20by%20Wilson,%20Emily.authcheckdam.pdf

[16] http://obamacarefacts.com/obamacare-womens-health-services/

against plans using domestic violence as a pre-existing condition. Should the law be repealed, survivors could be financially penalized for wanting to access the same benefits at the same cost as their peers.

Women are more likely than men to be covered as dependents (39% of women between the ages of 19 and 25 are covered as dependents under a parent's or a spouse's plan). Many victims of domestic violence have been forced to stay in abusive relationships to maintain health insurance particularly if they or a child have a disability or chronic medical issue.[17] By providing access to more good health insurance at a reasonable cost, the Affordable Care Act removed one of the barriers keeping women trapped in violent marriages.[18]

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To avoid the disastrous consequences, I have outlined, I am certain that you, your colleagues on both sides of the aisle and other elected and appointed leaders will seek every resource and idea to close the gap and allow Pennsylvania to continue to provide essential, life-saving services to people with disabilities. At some point, you may be tempted to think that philanthropy might be counted on as the safety net. I want to provide a little context to explain why this cannot and will not work.

First, while there are more than 6500 charitable grantmaking foundations in PA, and total foundation giving is $2.7 billion, that is a small fraction of the PA budget. Individuals contribute more than twice as much to charity, at $6.74 billion annually, also still dwarfed by government spending.[19] Philanthropy cannot replace public sector funds. The numbers don't work.

However, there are important ways that foundations can be good partners in strengthening access to healthcare, improving the lives of Pennsylvania's most vulnerable citizens, and fine tune legislative solutions. Foundations can commission nonpartisan research and analysis to inform decision-making; as a neutral convener, foundations can bring together experts and community leaders to discuss problems and offer solutions; and foundations can partner with government to pilot test and evaluate model programs.[20]

Thank you.

ATTACHMENTS:

- Philanthropy Fast Facts March 2017, prepared by Grantmakers of Western Pennsylvania
- How Philanthropy helps build a better Southwestern Pennsylvania, prepared by GWP

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[17] Futures Without Violence. https://www.futureswithoutviolence.org/3-things-at-stake-aca/

[18] Kaiser Family Foundation Fact Sheet on Women's Health Insurance Coverage. http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage

[19] Philanthropy Fast Facts March 2017, prepared by Grantmakers of Western Pennsylvania

[20] How Philanthropy helps build a better Southwestern Pennsylvania, prepared by Grantmakers of Western Pennsylvania

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FISA Foundation is a charitable grantmaking foundation dedicated to improving the lives of women, girls and individuals with disabilities in southwestern Pennsylvania. Service area: Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, Westmoreland

BIOGRAPHICAL STATEMENT

Kristy Trautmann has served as Executive Director of FISA Foundation since 2010. Previously, she served as the Foundation's Program Officer since 2004. Under Ms. Trautmann's leadership FISA has led regional efforts to improve access to health care for people with disabilities, assist arts and cultural organizations to be accessible to people with disabilities, end cycles of domestic and sexual violence (Southwest PA Says No More), address inequities for vulnerable girls. She oversees $1.5 million in annual grants as well as a diverse portfolio of projects promoting civic engagement, self-advocacy, accessible housing and community-based employment for people with disabilities. Prior to working at FISA, Ms. Trautmann was the Director of Asset Development Programs at the YWCA Greater Pittsburgh, and provided community education and training at Pittsburgh Action Against Rape. She is the founder and former co-chair of the Girls Coalition of Southwestern Pennsylvania. Ms. Trautmann also serves on numerous other boards and advisory committees, including: 21 and Able (*a United Way initiative focused on improving the transition to adulthood and employment for young adults with disabilities*), the steering committee of the Health Literacy initiative of the Hospital Council of Western PA, UPMC's Disability Resource Center, and the Finance Committee for Grantmakers of Western Pennsylvania. Ms. Trautmann earned a Master of Science in Nonprofit Management from the Bayer Center for Nonprofit Management at Robert Morris University and a Bachelor of Science in psychology from the University of Pittsburgh, and is a graduate of Leadership Pittsburgh, XXVI.

SUMMARY OF TESTIMONY

The Affordable Care Act has been the most significant law to promote health and well-being of people with disabilities since the Americans with Disabilities Act. The ACA has unquestionably improved access to care for people with disabilities and chronic conditions to help them live healthy, independent, and fulfilling lives. In Pennsylvania, people with disabilities account for 25% of Medicaid enrollment but 50% of program spending; block grants and per capita limits will disproportionately affect individuals with disabilities. Medicaid provides long-term care services that support people with disabilities' ability to live independently and safely in the community. Reductions in Medicaid coverage will weaken community-based services supports for people with disabilities, dramatically increase waiting lists, cause needless institutionalization and likely result in premature deaths. Repeal of the ACA will also put victims of domestic violence in danger. Foundations can be an important partner in strengthening health access, but philanthropy cannot replace or fill the gaps in government programs and safety-net services.

Healthcare Council of Western Pennsylvania
Testimony for House Democratic Policy Committee Hearing
On Affordable Care Act/Medicaid Expansion Repeal
March 29, 2017

Presented by: A.J. Harper, President
Healthcare Council of Western Pennsylvania

I want to thank you, Representative Frankel, and members of the House Democratic Policy Committee for the opportunity to speak on the Affordable Care Act specifically as it relates to the expansion of Medical Assistance. My remarks focus on Medicaid expansion and a possible repeal as it relates to western Pennsylvania hospitals and the communities they serve.

My name is A.J. Harper and I am the President of Healthcare Council of Western Pennsylvania. I testified in front of you four years ago, supporting the expansion of Medical Assistance in Pennsylvania. What I said then is even truer today: Medicaid is of particular important to western Pennsylvania, due to the large vulnerable population our member hospitals serve.

Since that time, Pennsylvania has become an expansion state and now more than 700,000 individuals are covered under Medicaid and their insurance coverage could be jeopardized if Medicaid expansion is repealed. Our first priority is to ensure continuity of coverage and care through access to a robust delivery system.

If Medicaid expansion would be repealed, not only would many Pennsylvanians lose coverage, Pennsylvania hospitals could see charity care and bad debt double. Since Medicaid expansion, Pennsylvania hospitals saw charity care and bad debt drop by 9 percent during 2015. Pennsylvania hospitals have and continue to be the safety net providers of care for those on Medicaid and for other vulnerable populations.

At the same time, I need to note that western Pennsylvania hospitals see a high percentage of patients that are either on Medicare or Medicaid. According to Healthcare Council's most recent Flash Survey for fiscal year 2016, more than 70 percent of inpatient admissions to the region's hospitals are from patients on Medicare or Medicaid. Obviously, any limitations on Medicaid expansion would have a dramatic impact on these "safety net hospitals."

The most financially fragile hospitals in the region are those that are critical access hospitals and those hospitals that are smaller than 100 beds. These hospitals are often in more rural areas of the region and often, are further away for patients. These hospitals are also economic drivers in their communities, and many times are the largest employers. Any rollback of Medicaid would gravely threaten access to care for those patients that may not be able to travel for care.

A rollback on Medicaid expansion could also have a chilling impact on the economy of the small towns and rural areas of western Pennsylvania. A repeal of the Affordable Care Act without replacement would hurt the economy of the entire state. Pennsylvania hospitals contribute $115 billion to the state's economy and support 625,394 jobs (HAP).

According to Healthcare Council's year-end Flash Survey, 24 hospitals or 40 percent of hospitals overall saw a loss from operations while 28 hospitals, or 47 percent of hospitals had a reduction in the number of full time equivalent staff.

Of even greater concern, is the continuing decline in operating margins for the region's smallest hospitals-those under 100 beds. These hospitals have had operating losses every year since 2009 and the operating margin for these hospitals is a negative 3.89 percent, which is worse than the prior year. Our region's critical access hospitals, those hospitals in the most rural communities, also saw a negative operating margin of 2.74 percent.

And, just a note about the region's critical access hospitals-even though they serve the most rural populations, they saw 8,400 admissions, had 81,000 emergency room visits, employ more than 2,000 full time equivalent staff and provided $20.7 million in uncompensated care in fiscal year 2016. These hospitals serve people who may not be able to get to another hospital during an emergency.

As a side note, I want to share with you that we at Healthcare Council see some of the individuals who are applying for insurance either on the insurance exchange or through Medical Assistance. We are a partner in the grant that the Consumer Health Coalition received through the Centers of Medicare and Medicaid Services (CMS) to assist individuals with enrollment. We have some additional funding that supports our navigator. Just yesterday, she spent three hours helping a family enroll during the special enrollment period. We see the importance of individuals and families having the ability to access care almost daily at Healthcare Council.

As far as the ideas to change the way enrollment works, we would suggest expanding the open enrollment period for 2018 to the same period of time as it was in 2017. The open enrollment period for 2017 began in November 2016 and concluded at the end of January 2017. In a proposed rule, CMS is suggesting that the 2018 open enrollment period would be a six-week period-from November 1, 2017 to December 15, 2017.
Obviously, a longer open enrollment period gives more people time to enroll. We also suggest that the CMS continue advertising for the exchange during open enrollment periods and for enrollment for qualifying life-changing events, like they had been doing in the past. We realize these changes are beyond the scope of the state, but it would be helpful if you and other state legislators let our Congressmen and Senators and let them know that these things are important to those needing access to care.

First and foremost, a repeal of Medicaid expansion would impact the ability of individuals to receive primary care through Medicaid. A repeal could result in patients not seeing their physicians, and then ending up in a hospital emergency room with a more advanced disease or condition that could jeopardize the long-term health of an individual and be much more expensive for the patient to be treated in the emergency room.

In closing, a repeal of Medcaid expansion would have a negative impact on all of the region's hospitals, but will have an even greater impact on small and rural hospitals throughout the region. This, in turn, could jeopardize the ability of these hospitals to continue to provide the safety net to the most vulnerable people in their communities.

Thank you and I would be happy to answer any questions.

A. J. Harper
President
Healthcare Council of Western Pennsylvania

A. J. Harper assumed the position of President of the Healthcare Council of Western Pennsylvania in July 2005. Healthcare Council represents the interests of over 60 hospitals, long-term acute care, and long-term care facilities in the 32 counties that comprise Western Pennsylvania.

Mr. Harper earned a Bachelor's of Science in Health Information Management, School of Allied Health, College of Medicine at The Ohio State University, and an MBA from Baldwin-Wallace College in Berea, Ohio.

During his 25-year career in Cleveland, Ohio, Mr. Harper worked in the community and tertiary setting. His operations experience includes serving as Administrative Director of Medical Operations at the Cleveland Clinic Foundation; Vice President, Care Management at Marymount Hospital; a member of the Cleveland Clinic Health System; and, Administrator for the Lake/University Ireland Cancer Center, a freestanding comprehensive cancer center.

Mr. Harper gained association experience while serving as Vice President, Professional Services at the Greater Cleveland Hospital Association. In addition he has performed consulting for long term care and freestanding imaging centers throughout Ohio.

HEALTHCARE COUNCIL
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WRITTEN TESTIMONY OF CHRISTIE HUDSON, MPA, MSW, LCSW

CLINICAL SOCIAL WORKER, THERAPIST

BEFORE THE HOUSE DEMOCRATIC POLICY COMMITTEE

PITTSBURGH, PA

MARCH 29, 2017

I have been a Licensed Clinical Social Worker (LCSW) in the State of Pennsylvania since December of 2010. I have been a private practice therapist since that time. My practice is located in Mt. Lebanon, PA, in the South Hills of Pittsburgh. My primary specialization is in treating adult men and women with Post Traumatic Stress Disorder (PTSD), especially as it relates to sexual trauma. I am currently credentialed with numerous commercial insurance companies. I am also a Medicaid provider for the State of Pennsylvania. As a bit of background, I made the decision to transfer my Medicaid credentialing, a rather lengthy process, from the agency I worked at prior to my transition to private practice because I believe that our most vulnerable populations deserve quality mental health and addiction treatment, and their options should not be limited to Community Mental Health agencies. It is an unfortunate reality that practitioners in Community Mental Health agencies, while providing an invaluable and necessary service to the public, can often be newer to the field and less experienced at working with complex clients, or seasoned but overworked and often burned out. It was also my, and I'm sure many other's, experience that the pay scale available in Community Mental Health does not come close to level of education and skill required to perform in this job. Masters level practitioners like myself often move into private practice because of the flexible work life and greatly increased pay available. There is a down side to being self-employed relevant to this discussion, which I will address in my testimony a bit later.

To begin, I will address the changes to my caseload and practice since the implementation of the Affordable Care Act, and especially Medicaid expansion. When I began seeing clients in private practice in 2010, I was contacted for services by very few potential clients with Medicaid as their insurance provider. At that time, Medicaid was only available to our poorest citizens, most of whom were unable to work because of ongoing and disabling health and mental health conditions. My Medicaid client caseload tended to stay between 2-3 clients per week of a weekly caseload of 20-22. Again, these clients were poor, unemployed, and typically with serious and debilitating physical and/or mental health and sometimes co-occurring or historical substance use disorders. The remainder of my client caseload were people who had private insurance through their employer or who could afford to pay out of pocket. The ACA and Medicaid expansion has done what it intended to do and "covered the gap" of uninsured citizens by bringing coverage and services to the working poor and to people who did not have affordable and meaningful healthcare coverage available to them through their employer. The ACA dramatically changed the "face" of my own caseload, especially those that have Medicaid as their healthcare provider. While there is a component of my Medicaid client base that remains unchanged, I am now treating a new kind of client: the working poor. Those now covered by the ACA and Medicaid expansion encompass a variety of citizens that previously had no coverage for health or behavioral healthcare, so their needs went largely unmet, especially in regards to behavioral healthcare. On any given week, my Medicaid client caseload has at least doubled. Last week alone I saw six clients covered by Medicaid, three of whom most likely qualified for coverage under Medicaid expansion. In addition, two of my clients last week had insurance through the healthcare marketplace. In the past, I used to

receive very few calls over the course of a month for people seeking services who were covered by Medicaid, I now regularly receive several phone calls a week during peak season from people with Medicaid coverage.

I want to offer a few examples of the kinds of people I now get the privilege to treat because of the ACA. In the past year, I had the privilege of treating a working single mother who went untreated for her bipolar disorder for numerous years because of a lack of insurance. Her ability to seek therapy and psychiatric care became possible under Medicaid expansion. Another example from my practice is another working single mother who needed therapeutic support as she went through some major life changes, including the end of a long-term relationship, as well as going back to school to help stabilize and improve her earning potential for her family in the long term. Coverage for her care was made possible by Medicaid expansion. A final example comes from healthcare coverage available through the healthcare marketplace. A woman I have treated off and on for several years recently returned to treatment because of a serious addiction issue. While she does not qualify for Medicaid, she has been able to purchase healthcare through the marketplace and this insurance provides coverage for the treatment of her addiction. These women would have all continued to struggle without treatment, some with very serious potential consequences, were it not for the provisions of the ACA.

While I know that the current administration's efforts to repeal and replace Obamacare have failed, I do not believe for one moment that this fight is over. Poor people, especially sick poor people, have been a convenient villain and scapegoat long since before this administration, and will remain so long after, if history has any bearing on future outcomes. Some of the now-failed proposed provisions under the repeal and replace effort had the potential to re-cripple these vulnerable populations who were finally able to begin getting the care they need. Block grant funding for Medicaid was on the table. This would almost certainly change who and how my clients are covered here in Pennsylvania. My fear as a behavioral health provider is that treatment for behavioral healthcare and inpatient or intensive outpatient addiction treatment would be the first types of services to be capped or eliminated in order to maintain coverage for those now included under the expansion. There was also the idea of a work requirement for Medicaid benefits. I'm no policy expert but it has certainly been my experience that the people I treat who qualified for Medicaid under the ACA were already working if they were actually able to. To somehow suggest that adding this provision would stop poor people from "freeloading" is insulting to an already overstressed and overburdened population. Not to mention that it continues our pervasive scapegoating of the poor and working poor. To illustrate how absurd this requirement is, the state of Ohio found that Medicaid expansion had made it easier for beneficiaries to actually find work.

On a final and personal note, I am a living example of the necessity of quality healthcare. As a white educated woman I most certainly benefit from privilege. However, illness is the great equalizer. I am extraordinarily lucky that I happened to return part time to my previous job at the University of Pittsburgh, where there are tremendous healthcare benefits available to employees, when I decided to go into private practice. This was a decision based in part on the difficulty and expense of purchasing healthcare when one is self-employed at the time in which I went into private practice. This employment blend has worked well for me for the past 7 years. Like most healthy privileged people, I didn't think much about my healthcare, I just appreciated having it and that it didn't cost me much because of my job at Pitt. This all changed in the fall of 2014 when I became very ill. I was eventually diagnosed with an autoimmune Inflammatory Bowel Disease and became what is termed a high health care utilizer. While I am healthy today, it takes the care of specialists and some very expensive medication to keep me healthy. All of my life decisions are now based around my ability to maintain access to quality healthcare, and will be for the rest of my life. I will never be able to be without quality

healthcare, without my doctors and medication I will become severely compromised and very likely unable to work with any consistency. My entire quality of life, and my career, my ability to serve the people I just talked about, hinges on my access to health insurance. And I'm one of the lucky ones. My education and status afford me access to high quality healthcare, for the time being. If this had happened before I finished my education, I might not have been in a position to be here today. With the implementation of the Affordable Care Act I became cautiously optimistic that I would be able to be a full time practitioner again and not be required to maintain a second job because of access to healthcare benefits, or possibly leave my practice entirely once my boss retires. This is, frustratingly and sadly for me, a very real possibility. Imagine for a moment what it's like that life as you know it rests entirely on your access to quality healthcare? I am not unique in this. I am privileged enough to have options still though.

I am grateful and relieved that the Affordable Care Act will remain in place for the time being, and that I will continue to be able to provide treatment to the individuals I currently serve and will serve in the future as a direct result of the ACA. My hope is that if and when it goes on the chopping block again the groundswell of opposition will be enough to keep the ACA in place. I appreciate the opportunity to offer my testimony to the House Democratic Policy Committee. Thank you.

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Christie is a Licensed Clinical Social Worker (LCSW) in private practice in Pittsburgh, PA. After receiving her Master of Social Work degree from the University of Pittsburgh in 2007, Christie completed her post-graduate clinical work at Pittsburgh Action Against Rape (PAAR), Allegheny County's rape crisis center. At PAAR, Christie received extensive training and experience in working with adult sexual trauma survivors. Currently, she specializes in the treatment of Post-Traumatic Stress Disorder (PTSD), complex PTSD, and dissociative disorders, and primarily uses a relational and adult attachment approach to her work with trauma survivors, as well as Eye Movement Desensitization and Reprocessing (EMDR) for focused trauma work. In spring 2015, Christie completed the two-year Gestalt training program through the Gestalt Institute of Pittsburgh. In addition to her clinical work, Christie manages the Center for Healthcare Management, housed at the Katz Graduate School of Business at the University of Pittsburgh.

TESTIMONY SUMMARY

The testimony of Christie Hudson, LCSW will include the following:

- Background as a Medicaid credentialed behavioral health provider in private practice
- Changes in Medicaid client caseload since the implementation of the Affordable Care Act
- Examples of clients who now have access to behavioral health services through the ACA and Medicaid expansion
- The potential impact of a few of the proposed repeal and replace provisions on behavioral health services
- Personal example of the necessity of access to quality healthcare

WRITTEN TESTIMONY OF ELIZABETH CUEVAS, MD

BEFORE THE HOUSE DEMOCRATIC POLICY COMMITTEE

PITTSBURGH, PA

MARCH 29, 2017

I want to thank you for allowing me to participate in this very important hearing on the Affordable Care Act and the significance of Medicaid expansion. I am here as a primary care physician and am providing this testimony on my own behalf.

To appreciate my perspective of the health care landscape of Pittsburgh, I think it would be helpful to first know my background. I attended medical school at the University of Pittsburgh, graduating in 2001. From there, I was fortunate and admitted to a Harvard residency program in Boston at the Massachusetts General Hospital. After finishing training in 2004, I stayed on at the hospital, working in a general medicine outpatient practice part-time and also at the Boston Health Care for the Homeless Program for the other half of my time. My Boston colleague always equated Massachusetts health care to the "Disney World" of health care access, as it was in 2006 that the state passed health care reform law. Taking care of the poorest of its citizens was made possible by this law and I was able to screen homeless patients for cancers, treat their chronic conditions, and prescribe necessary medications which they could easily access. This early part of my career taught me that access to comprehensive health care was often one of the most important steps towards addressing the many social determinants of health that leads to early morbidity and mortality.

I moved to Pittsburgh in 2011 and began work delivering primary care services precepting residents in an Internal Medicine clinic in the north side of Pittsburgh. Of course, this was the time before the Affordable Care Act came into law. As is typical in medicine resident-based primary care clinics, our physicians-in-training see a disproportionately high Medicaid population as compared to the commercially insured. And only a very few who come to our clinic are self-pay. Unfortunately, because the care of the self-pay patient is entirely out-of-pocket, it is extremely difficult to order routine health maintenance testing, such as fasting cholesterol blood levels, mammograms, and colonoscopies. Additionally, achieving adequate control of a patient's chronic disease so as to avert hospitalization and comorbidities is virtually impossible because patients just can't afford the tests, medications, and specialty appointments necessary. Initially, I was shocked by what I was seeing and taking care of in clinic. It became routine to see young 20 to 40 year old men and women with shockingly high blood pressures or child-bearing aged women who were not up to date with cervical cancer screening and without access to contraception. To me, after practicing in a state for 10 years where a very high percentage of patients had access to and received comprehensive health care, this was astonishing. In my new clinic, patients would be enrolled in and lose their health insurance quickly so I quickly learned which medications were the cheapest and how to treat disease without the testing I normally would have recommended.

In the second year I worked in the clinic, I met Ms. J, a young 24 year old uninsured mother of two, who finally paid the fee to come in to see us because she was feeling so poorly. She was fatigued and

urinating frequently. Her symptoms had progressed to include light-headedness which had started to interfere with her ability to finish her shifts at a local fast food restaurant. Her diagnosis was easy and didn't take much to figure out. The diabetes had struck her quickly, causing extremely elevated blood sugars that her body tried to eliminate by processing it through her kidneys and into her urine. Unfortunately, effective treatment is much more difficult. Proper treatment of diabetes requires knowing what the blood glucose is multiple times a day with a device called a glucometer. The glucometer calculates the circulating sugars in the bloodstream by analyzing the blood from a finger prick placed on a test strip. For very high blood sugars, such as what Ms. J had, patients often need two different types of insulin, a long-acting formulation of insulin to bring the elevated average blood sugar down over the course of the day as well as a short-acting insulin that can lower the sudden blood sugar surge that comes from a meal. How much insulin Ms. J needed depended on the glucometer testing. Thankfully, glucometers are easy to get, but the device's test strips, each only being able to be used once, are costly. Ms. J could not afford the test strips, much less the insulin. Additionally, she could not pay for the costly other tests that normally accompanied adequate evaluation of new-onset diabetes. Pre-ACA, we did the best we could. Though diabetes can have devastating consequences as it does its damage over years of battering a body's internal organs, it had not yet had its chance to do so in Ms. J. She was not disabled and was able to work; consequently, she did not qualify for Medicaid at that time. We enrolled Ms. J in a pharmaceutical discount plan so that she could get insulin at reduced costs. She tested her blood sugars less often since the test strips were expensive and we only gave her the long-acting insulin so that she would not be at risk for the hypoglycemia that can come with administering short-acting insulin without knowing the blood sugars. We did not check her cholesterol or follow her kidney function or refer her to an ophthalmologist to examine her eyes to look for the sequelae and complications of uncontrolled diabetes. We saw Ms. J just a handful of times back then, with some intermittent insulin refills between visits. Ms. J often missed her daily insulin doses as she tried to stretch out the medication to make it last longer. Eventually, she was lost to follow-up, another patient missing due to poor access to health care.

Once the health care exchanges opened after the passing of the ACA and Medicaid expansion became a reality in our state, our clinic saw an influx of patients, newly insured after years of never seeing a doctor. We heard countless stories from new patients who presented with complaints of indigestion, weight loss, cough, joint pains, and chest pains, relieved that they finally had the ability to get their health concerns addressed and treated. For so many, this was the first time they were able to access health care *in years*. If I had more time, I would tell you about the under-65 year old smoker, not yet eligible for Medicare, a custodian downtown who presented with a neck mass. It had been growing over the course of the month and he saw us for the first time, thankful that he had recently signed up for insurance through the health exchange. His neck CT scan and subsequent biopsy was covered by his new insurance and now so will his chemotherapy and radiation for his newly discovered head and neck cancer. Or I would tell you about the 40-something year old construction worker who fell at work, fracturing several vertebrae, landing him in the hospital and needing spinal surgery to stabilize his spinal column. Rather than facing a future of bankruptcy and subsequent homelessness secondary to this very expensive hospitalization, he qualified for Medicaid, which covered the surgery and the necessary physical therapy to heal. Or I would tell you about the 50-something year old woman who lived in an

abandoned house, brought into the hospital with a COPD exacerbation. Though she had no insurance initially, she also easily qualified for Medicaid. This allowed not only the proper treatment to heal her lungs, but also covered the work-up and treatment of the lung mass that was subsequently found, a treatable lung cancer. But, instead, let me return to Ms. J's story.

Ms. J came back to see us in clinic this past year, having been absent from the clinic for almost 3 years. In the interim, she had been to the emergency room countless times and admitted to the hospital for diabetes complications another handful of times. Remember, she is still in her 20's. She had just signed up for Medicaid, made possible because of the expansion. Over these last few years, Ms. J has been working, but life was tough as she had to prioritize making ends meet and caring for her kids over her own health. But now she was starting to experience numbness in her feet, making it harder to stand for her long work shifts. High blood sugars can start to cause damage to nerves, most evident in those nerves that are farthest from the brain, i.e. the bottom of her feet. Based on a simple blood test, we could tell that her blood sugars ran 3 to 4 times higher than normal levels. But this encounter was different than past ones. Ms. J now had health insurance in the form of Medicaid. We ordered further blood and urine tests. We prescribed all the test strips she needed to check her blood sugars four times a day. Because we could now monitor her fluctuating sugar levels, we prescribed both forms of insulin. Additionally, and perhaps most importantly, we referred her to a comprehensive diabetes center, where her insurance would allow her access to a dietician, behavioral health counselor, endocrinologist, pharmacist and nurse. All of these new members of her health care team could provide wrap around services to try to get her raging diabetes under control. We are still early in Ms. J's story and I don't yet know the ending. But Medicaid expansion has given her an opportunity. From my experience in my clinic prior to Medicaid expansion, without access to a reliable and sustainable form of health insurance, I knew what trajectory her life had previously been taking. After all, I had seen it many times before in the form of other middle-aged women with kidney failure requiring dialysis or long-standing outrageous hypertension leading to early heart attacks or chronic unremitting pain due to neuropathy, all from long-standing, uncontrolled diabetes that had started early in life, just like Ms. J. But now, Ms. J had a chance to jump off this path that led to disability and onto one that could lead to better health outcomes, improved quality of life, longer life span, and reduced overall health care costs. Though I do not yet know what the coming years will bring for Ms. J, I do know with reasonable certainty, that without access to health insurance and thus, health care, she will not survive her diabetes. Now, now, she has a chance.

Elizabeth Cuevas, MD

Allegheny General Hospital

Dr. Elizabeth Cuevas is a primary care physician in the Pittsburgh region. Dr. Cuevas graduated from medical school at the University of Pittsburgh in 2001. After her residency at Harvard, she continued working for the Massachusetts General Hospital while also working as a primary care physician for the Boston Health Care for the Homeless Program. Upon moving to Pittsburgh in 2011, Dr. Cuevas began working as a primary care physician at the Allegheny General Hospital Internal Medicine Clinic, which serves disproportionately high Medicaid population as is typical in medicine resident-based primary care clinics. In 2014, Dr. Cuevas co-founded the Center for Inclusion Health at the Allegheny Health Network. She currently also directs the Inclusion Health Track at Allegheny Health Network's Internal Medicine Residency Program.

Pennsylvania Health Funders Collaborative
& Jewish Healthcare Foundation
March 29, 2017

Comments to the Democratic Policy Committee

We should not lose the progress we have made in reducing the number of uninsured in Pennsylvania; most of which was through Medicaid Expansion.

- Over 1 million uninsured Pennsylvanians have benefited from affordable health care coverage, reducing our uninsured rate from 17% in 2013 to 6.4% in 2016, making Pennsylvania the 15th lowest in the country. This has made a tremendous difference in their health, their families' wellbeing, and their ability to work and pay taxes.

We need to be mindful of the large impact federal health care funding has on Pennsylvania's economy, including the jobs it creates and the needed state tax revenues that flow from those jobs and related economic activity. During the first 12 months of Medicaid Expansion in Pennsylvania, a report by the Pennsylvania Department of Human Services showed:

- $1.8 billion received by health care providers,
- 15,500 jobs added due to increased health care spending,
- $2.2 billion in economic output,
- $53.4 million in additional state tax revenue, and
- $92 million decrease in uncompensated care at hospitals (which has grown to a $280 million decrease in 2016)

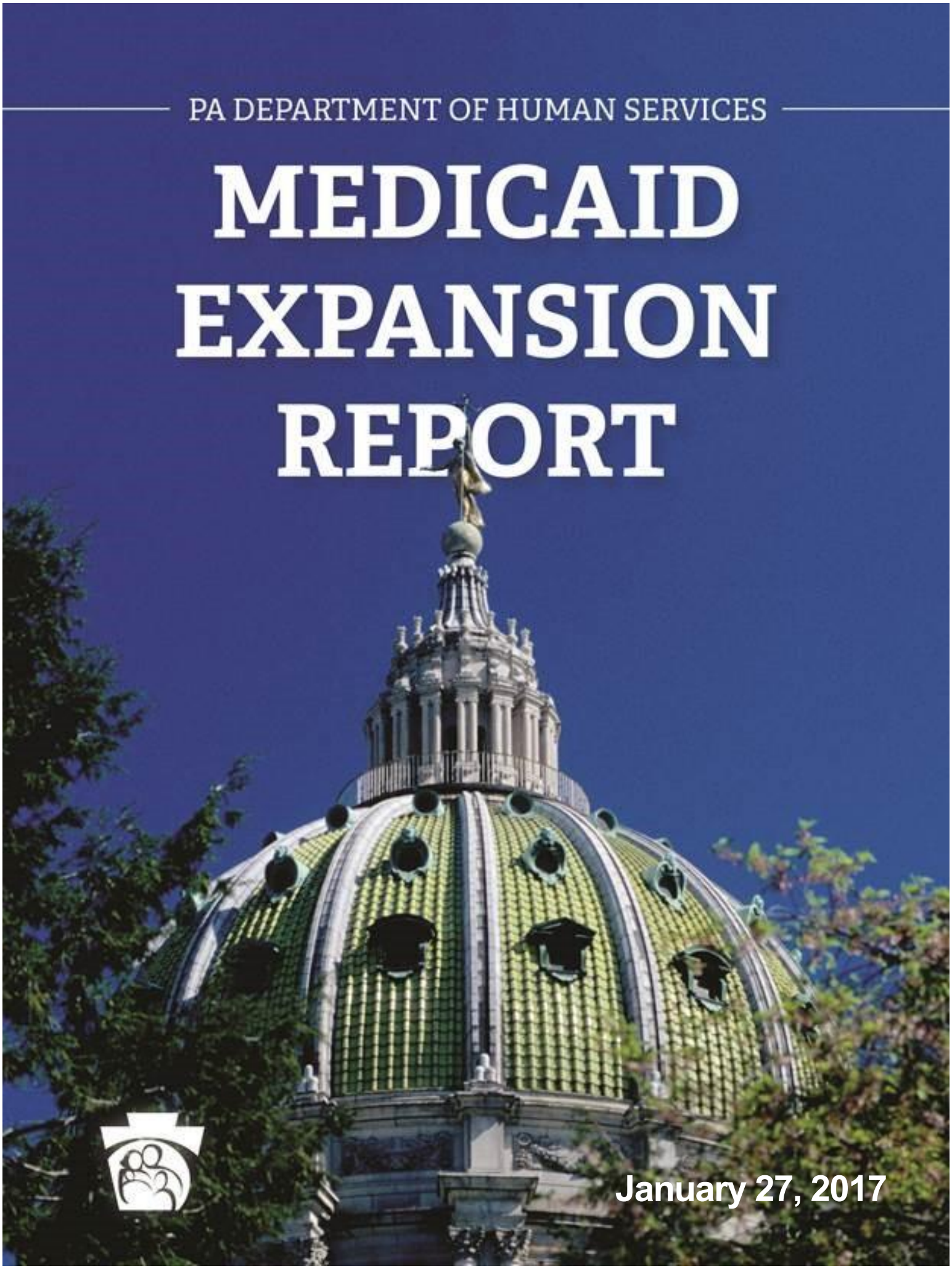
Looking to the future, a report by the Commonwealth Foundation and George Washington University suggests that repealing Medicaid Expansion would cost Pennsylvania:

- 90,700 jobs in 2019 (40,300 from health care),
- $26.9 billion in federal funds from 2019-23,
- $84.18 billion in business output from 2019-23, and
- $1.6 billion in tax revenue from 2019-23.

A change in how the federal government funds Medicaid to per capita caps would not only significantly increase Pennsylvania's uninsured rate, but would also be harmful to its economy. Since 1965, the Medicaid funding formula has been guaranteed at an adjustable rate with no caps or waiting lists. This keeps up with medical inflation and new technologies. With per capita caps, funding is caped per enrollee based on a formula that does not keep up with new technologies or medical inflation. With per capita caps, the Congressional Budget Office found that on average, states would receive 25% less federal Medicaid funding. Compared to other states, Pennsylvania would not fare well in a Medicaid per capita system for three main reasons:

- The per capita formula proposed to be used had an average annual growth rate from 2010-2014 of 2.8% compared to Pennsylvania's 5.9% average annual growth for Medicaid Spending, with the national average being 5.2%.
- Pennsylvania's Medicaid population includes more seniors and people with disabilities who use more healthcare and long-term care services.
- Pennsylvania has already moved towards Medicaid managed care, and as a result, the State will have fewer cost-saving options for responding to new fixed funding.

Changing federal funding to per capita caps will not only have the potential to erode the coverage gains that have been made in Pennsylvania, but also cause significant loss of jobs and will significantly add to Pennsylvania's budget deficit issues.


PA DEPARTMENT OF HUMAN SERVICES
MEDICAID EXPANSION REPORT
January 27, 2017

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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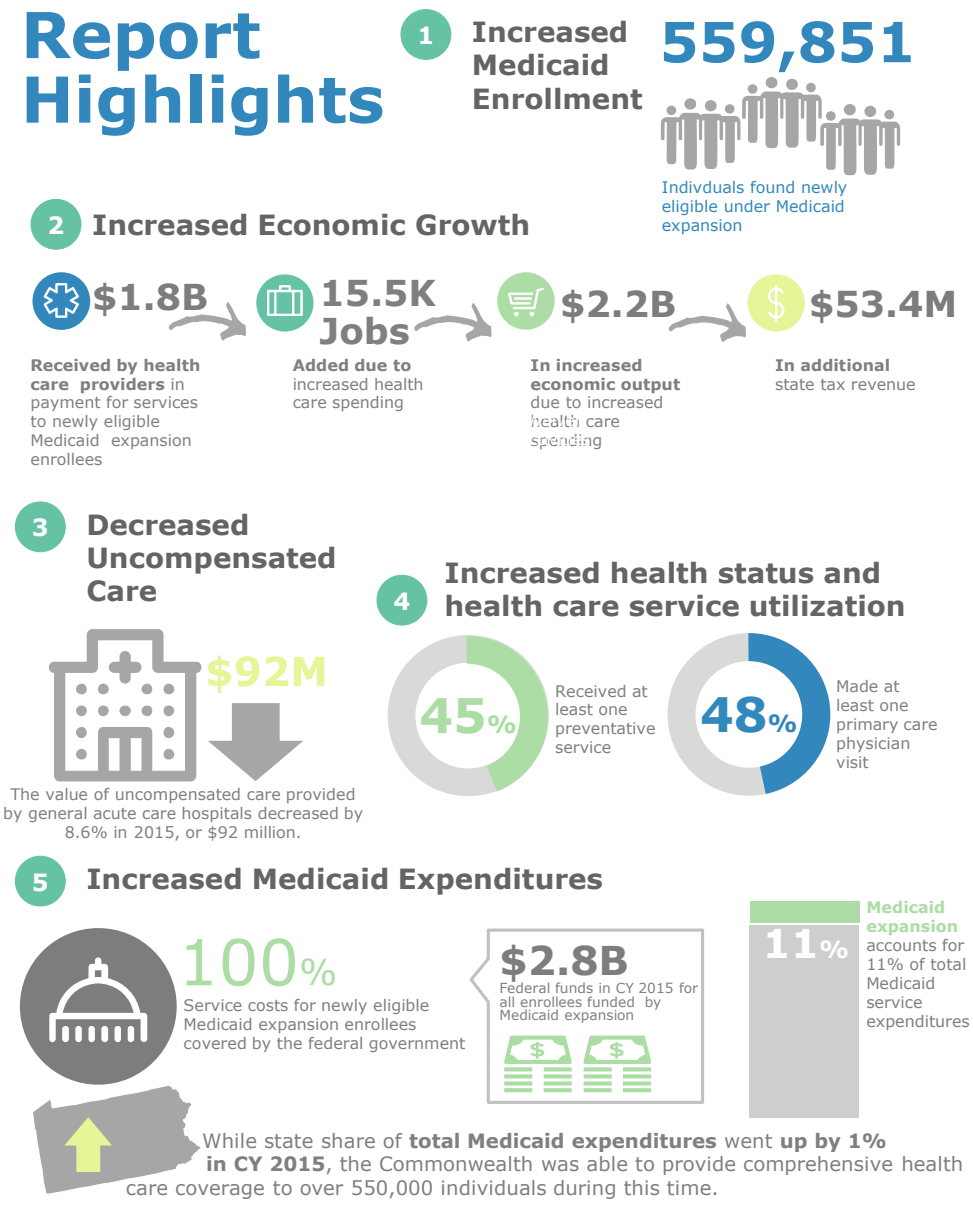
DEPARTMENT OF HUMAN SERVICES

1. Executive Summary

In January 2015, the Commonwealth of Pennsylvania (the Commonwealth) expanded Medicaid eligibility for individuals with incomes below 138% of the Federal Poverty Level (FPL) under a Section 1115 demonstration waiver called Healthy Pennsylvania (Healthy PA). The Commonwealth then withdrew its waiver and continued expanded Medicaid eligibility under the provisions of the Affordable Care Act (ACA).

The purpose of this report is to examine what impact the first year of Medicaid expansion had on Medicaid enrollment, uninsured rates, the Commonwealth's budget, and the overall economy. The report also examines the new enrollees' demographic and utilization characteristics and compares those characteristics to those of a comparable group of traditional Medicaid enrollees.

Figure 1. Executive Summary



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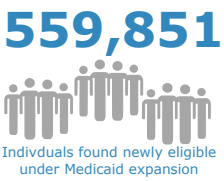
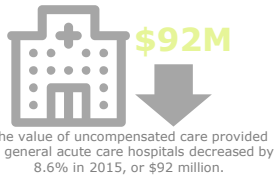
Increased Medicaid enrollment and reduced the uninsured rate. At the end of Calendar Year (CY) 2015, 559,851 individuals were enrolled in the Medicaid expansion program. Between December 2014 and December 2015, every county in the Commonwealth experienced an increase in Medicaid enrollment that ranged from 14% to 28%. The uninsured rate for adults between the ages of 18 to 64 years old in the Commonwealth decreased from 11.7% in 2014 to 8.7% in 2015.

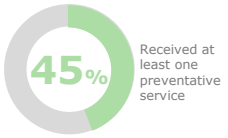


Increased economic growth. For CY 2015, health care providers received over $1.8 billion dollars in payments for serving newly eligible Medicaid expansion enrollees. The increased health care spending added an estimated 15,500 jobs. In addition, the increased health care spending is estimated to have increased economic outputs by $2.2 billion, and resulted in an additional $53.4 million in state tax revenue.

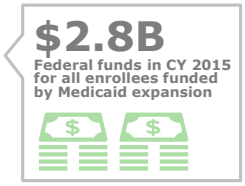
Decreased hospital uncompensated care. According to data compiled by the Pennsylvania Cost Containment Council (PHC4), the total dollar amount of uncompensated care to general acute care hospitals had increased each year from 2001 to 2014. In 2015, when Medicaid expansion occurred, the dollar amount of uncompensated care decreased by $92 million or 8.6%.



Increased health status and health care service utilization. The new adult benefit package administered by HealthChoices extended health care coverage, both for physical health and behavioral health, as defined by the ACA's Essential Health Benefits and federal parity requirements. Between March 2015 and April 2016, 380,018 newly eligible individuals, or 45% of the expansion population received at least one preventative service, and 48% (423,675 individuals) had at least one primary care physician visit. Twenty-seven percent (27%, 228,648 individuals) of the expansion population had at least one emergency room visit, and 5% (40,874 individuals) were admitted at least once to the hospital. A noteworthy percentage (17%, or 146, 694 individuals) of the expansion population had a cardiovascular condition. An additional 31% (261,737 individuals) of the expansion population were diagnosed with and/or treated for substance use disorder and/or mental health (SUD/MH) conditions.



Increased Medicaid expenditures. The federal government provided 100% of the health care costs for individuals meeting the federal definition of a Medicaid expansion enrollee, which were approximately $2.8 billion in CY 2015 and represented approximately 11% of the total Medicaid service expenditures.



The following report provides a more detailed analysis of these and related topics.

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2. Introduction to the First Year of Medicaid Expansion

2.1 Introduction

On March 23, 2010, the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), collectively referred to as the Affordable Care Act (ACA), were signed into federal law. The ACA included a provision that expanded access to Medicaid for low-income adults and families earning up to 138% of the Federal Poverty Level (FPL). On June 28, 2012, the U.S. Supreme Court handed down a ruling that allowed state-by-state decisions on whether or not to expand eligibility for their Medicaid programs to include this new population (*National Federation of Independent Business (NFIB) v. Sebelius, 2012*).

As of January 2017, 31 states and the District of Columbia expanded Medicaid under the ACA (see Figure 2), with seven states taking alternative approaches to implementing Medicaid expansion.[1] States that took alternative approaches used a Section 1115 demonstration waiver to implement expansion in ways that extend beyond the flexibility provided by the ACA and require approval from the federal Centers for Medicare & Medicaid Services (CMS).

Highlights

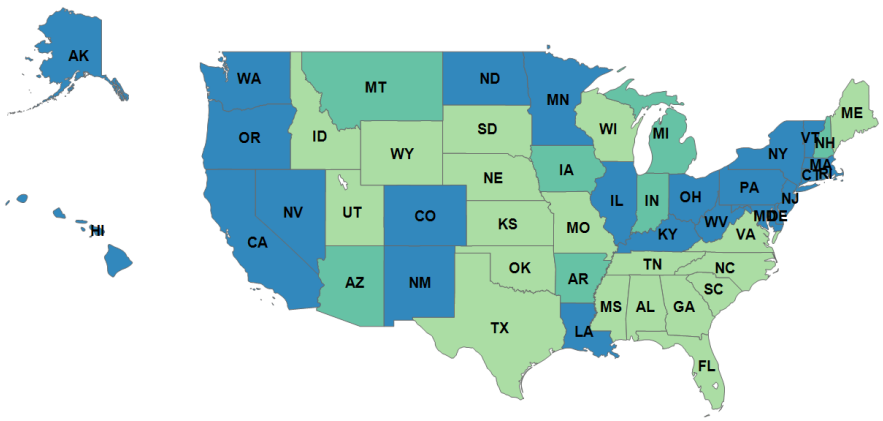
- Report assesses the initial impact of Medicaid expansion on enrollment, expenditures, and the economy for the first calendar year of Medicaid expansion, as implemented under Healthy PA and HealthChoices Expansion
- Medicaid expansion was first implemented under a Section 1115 demonstration waiver in January 2015 and then transitioned to traditional Medicaid expansion beginning in April 2015
- Expansion extends Medicaid coverage to nonelderly adults, 19 to 64 years old, with incomes up to 138% of the FPL
- HealthChoices Expansion's adult benefit package covers Essential Health Benefits
- The Department of Human Services (DHS) partnered with 400 community-based organizations to conduct outreach and provide enrollment assistance for Medicaid expansion
- The uninsured rate among nonelderly adults in Pennsylvania decreased five percentage points to 8.7% in 2015, which is below the national average of 13.1%

The federal government and state governments jointly finance Medicaid programs. The costs associated with newly eligible adults under Medicaid expansion are primarily funded by federal funds, covering 100% of related Medicaid expansion costs in

[1] Kaiser Family Foundation State Health Facts. *Status of State Action on the Medicaid Expansion Decision,* updated January 1, 2017. Retrieved from http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

Calendar Years (CYs) 2014 to 2016; 95% in CY 2017; 94% in CY 2018; 93% in CY 2019; and 90% in CY 2020 and subsequent years. Medicaid expansion also grants enhanced federal funding to states that expanded Medicaid coverage before the ACA to adults (i.e., non-pregnant adults, parents/caretakers and nonelderly adults with disabilities, traditionally eligible for Medicaid either under the State Plan or a demonstration waiver), whose income was up to the FPL.

Figure 2. States' Decisions on Medicaid Expansion



States' Decisions	No. of States	Map Color
Adopted Medicaid Expansion	24 states and DC	
Adopted Alternative Expansion under Section 1115 Demonstration Waiver (AR, AZ, IA, IN, MI, MT, and NH)	7 states	
Not Adopting at this Time	19 states	
Arizona received federal approval in 2016 to transition expansion coverage to Section 1115 waiver authority; implementation of the waiver provisions related to the expansion population are pending federal approval. Wisconsin provides Medicaid coverage for adults up to 100% of the FPL but did not adopt the ACA expansion.		
Figure Source: Kaiser Family Foundation State Health Facts. Status of State Action on the Medicaid Expansion Decision*, updated January 1, 2017. Retrieved from http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.*		

In January 2015, the Commonwealth of Pennsylvania (the Commonwealth) implemented Medicaid expansion using a Section 1115 demonstration waiver called Healthy Pennsylvania (Healthy PA), becoming the 28th state to expand Medicaid. In February 2015, the Commonwealth made the decision to replace Healthy PA with a traditional ACA approach to Medicaid expansion, and transitioned Medicaid expansion enrollees into the HealthChoices program, which is the existing Medicaid managed care program.

2.1.1 Background on this Report

With the close of the first year of Medicaid expansion, the Commonwealth developed this report to understand the initial impact on Pennsylvanians and the Commonwealth. This report analyzes the impacts over the first calendar year of Medicaid expansion (January 2015 to December 2015) on the Commonwealth's enrollment, expenditures,

overall economy, and population. Utilization of health care services was analyzed for the 12-month time period from April 2015 to March 2016. The goal of this report is to serve as a resource for state leaders, policymakers, the health care industry, and the public seeking to understand how Medicaid expansion has affected the Commonwealth in its first year of implementation.

2.2 Medicaid Eligibility Income Levels Before and After Medicaid Expansion

Prior to the ACA, the Medicaid program in Pennsylvania focused on providing health care coverage to certain groups of the Commonwealth's lowest-income population, primarily children, pregnant women, parents/caretakers of dependent children, individuals with disabilities, and the elderly. The ACA provided the Commonwealth with the opportunity to offer health care to a larger portion of the population—specifically to nonelderly adults with incomes up to 133% of the FPL. The ACA calls for income to be calculated using the Modified Adjusted Gross Income (MAGI) methodology and to disregard 5% of the total, which in effect raises the threshold to 138% of the FPL. Figure 3 depicts the income eligibility as a percentage of the FPL before and after expansion for a number of the Commonwealth's Medicaid eligibility categories for nonelderly adults. Pregnant women and workers with disabilities, who had eligibility levels above 138% of the FPL prior to expansion, did not change eligibility. Medicaid expansion provided eligibility for individuals under 138% FPL who were not previously covered including: parents/caretakers with dependent children over 38%, adults without dependent children, or adults without a disability over 100% FPL.

Figure 3. Pennsylvania Medicaid Eligibility Income Limits for Nonelderly Adults as Percent of the FPL, Before and After Medicaid Expansion

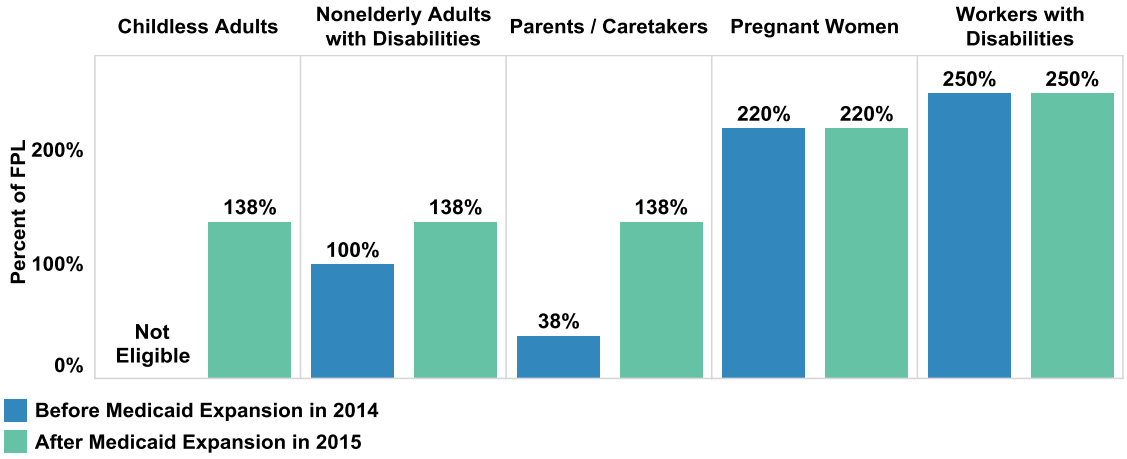


Figure Sources: PA DHS, Office of Income Maintenance. Expansion and FMAP Categories reference sheet. Provided on August 25, 2016 for the purposes of this report.

Kaiser Family Foundation. The Pennsylvania Health Care Landscape, April 25, 2016. Retrieved from KFF.org: http://kff.org/health-reform/fact-sheet/the-pennsylvania-health-care-landscape.

The ACA provided the Commonwealth with the opportunity to offer health care to adults with incomes up to 138% of the FPL. Table 1 contains the monthly and annual income limits for households determined by family size and in terms of the FPL for Medicaid expansion. As noted above Medicaid financial eligibility for most nonelderly adults is based on MAGI.

Table 1. 2016 Income Limits for Pennsylvania Medicaid Expansion Eligibility

Income Type by Number of Persons in Family/Household	Monthly Income Limit	Annual Income Limit
1	$1,317	$15,801
2	$1,776	$21,307
3	$2,235	$26,813
4	$2,694	$32,319
5	$3,153	$37,826
6	$3,611	$43,332
7	$4,071	$48,851
8	$4,532	$54,384
Each Additional Person	$462	$5,533

Table Source: *PA DHS, Office of Income Maintenance.* Expansion and FMAP Categories reference sheet. *Provided on August 25, 2016 and January 11, 2017 for the purposes of this report.*

2.3 Benefits Under the Healthy PA Waiver Demonstration

On August 28, 2014, CMS approved the Healthy PA program as an alternative to implementing Medicaid expansion as set forth by the ACA. The Healthy PA program was approved under a Section 1115 demonstration waiver. In addition to increasing the income level to qualify for Medicaid to 138% of the FPL, Healthy PA created three benefit packages to serve all nonelderly adults in Medicaid, including those who were eligible for Medicaid prior to expansion and those newly eligible after expansion.[2]

- A Private Coverage Option (PCO) benefit package for healthy (not at-risk) newly eligible adults
- A Healthy Plus benefit package for people who were ill or had chronic health problems
- A Healthy benefit package for other enrollees who were previously eligible before the expansion

CMS required that Pennsylvania make changes to the Medicaid State Plan in tandem with the Healthy PA waiver in order to implement the three benefit packages (i.e., PCO, Healthy Plus, and Healthy packages).[3] DHS submitted State Plan Amendments (SPAs) for these three benefit packages and on December 17, 2014, CMS approved the SPAs for two of the three packages, the PCO and Healthy Plus packages. DHS began enrolling individuals on December 1, 2014, and began providing coverage under the approved PCO and Healthy Plus benefit packages on January 1, 2015. Changes were also proposed to the existing Medicaid State Plan benefit package that most recipients previously received and designated as the Healthy benefit package. Table 2 identifies key distinctions between program components

See Section 8.6 in the Appendix for a detailed comparison on the services covered by these three benefit packages.

[2] The following individuals were excluded from these benefit packages under Healthy PA: 1) Individuals eligible for Medicare cost-sharing assistance. These individuals kept their current benefit package; 2) Individuals eligible for Buy-In only. These individuals did not receive a health care benefit package, but continued to have their Medicare Part B premium paid by Medicaid. 3) Children under age 21 years old.

PA DHS. Operations Memorandum #14-11-01, *Medicaid Eligibility Rule Changes Under the Healthy Pennsylvania 1115 Waiver (Healthy PA)*, November 6, 2014. Retrieved from *http://services.dpw.state.pa.us/oimpolicymanuals/ma/OPS141101.pdf*.

[3] PA DHS. *Centers for Medicare and Medicaid Services Special Terms and Conditions, No. 11-W-0029513, Healthy Pennsylvania.* Retrieved from dhs.pa.gov: http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_098847.pdf.

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Table 2. Highlights on Program Components Described in the Healthy PA Demonstration Waiver

Overview	PCO benefit package	Healthy Plus benefit package	Healthy benefit package
Eligible Population	Coverage for healthy newly eligible adults	Coverage for traditionally eligible and newly eligible people with high risk health problems	Coverage for traditionally eligible people with low risk health problems
Benefit Administrator	Administered through PCO health plans designed specifically for newly eligible adults	Administered through the existing HealthChoices Medicaid managed care organizations (MCOs)	Administered through the existing HealthChoices Medicaid MCOs
Benefits	Benefits based on Essential Health Benefits mandated by the ACA for Qualified Health Plans on the Exchange	Benchmark benefits based on largest insured commercial non-Medicaid HMO, Aetna POS 3.7., and similar to Medicaid benefits before 2015	Retained existing benefits in the Medicaid State Plan as the "interim" Healthy benefit package
Behavioral Health Benefits	Covered through PCO	Behavioral health coverage provided through separate HealthChoices Behavioral Health MCOs (BH MCOs)	Behavioral health coverage provided through separate BH MCOs
Premiums	Beginning in year two, state would have charged monthly premiums up to 2% of household income for newly eligible adults and certain currently eligible beneficiaries between 100% and 138% of the FPL	No premiums	No premiums
Co-Payments	All demonstration beneficiaries would have paid state level co-payments in demonstration year one. In demonstration year two, beneficiaries would only have co-payments for non-emergency use of the emergency room	Nominal co-pays consistent with current State Plan	Nominal co-pays consistent with current State Plan
Healthy Behavior Incentives	Beneficiaries could have reduced their premiums or co-payments by completing healthy behaviors in the prior year beginning demonstration year two	No healthy behavior incentives	No healthy behavior incentives

Table Sources: PA DHS. Centers for Medicare & Medicaid Services Special Terms and Conditions, No. 11-W-0029513, Healthy Pennsylvania. Retrieved from dhs.pa.gov: http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_098847.pdf.

Comparing HealthChoices Expansion to Section 1115 Medicaid Expansion Demonstration Waiver, Effective 1/1/15 to 9/30/2015 from Kaiser Family Foundation. Kaiser Family Foundation. Medicaid Expansion in Pennsylvania: Transition from Waiver to Traditional Coverage. Retrieved from KFF.org: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-pennsylvania.

2.4 Transition from Healthy PA Waiver to the HealthChoices Program

2.4.1 Overview of Transition to HealthChoices Expansion

In February 2015, five weeks after the implementation of Healthy PA, Pennsylvania announced its decision to transition away from the Healthy PA demonstration and transfer the Medicaid expansion population from PCO health plans into the existing HealthChoices managed care program, designated as HealthChoices Expansion. The Commonwealth withdrew the pending SPA for the Healthy benefit package in March 2015. The alternative benefit packages serving adults under Healthy PA were consolidated into a single benefit package for all adults, which was approved and implemented on April 27, 2015. Those with Healthy Plus and Healthy benefit packages kept their current HealthChoices managed care organizations (MCOs), and their underlying benefit packages changed to the new adult benefit package. DHS transitioned individuals from the nine PCO plans to HealthChoices MCOs in two phases throughout 2015.

Figure 4. Transition of Medicaid Expansion Enrollees from Healthy PA to HealthChoices Expansion

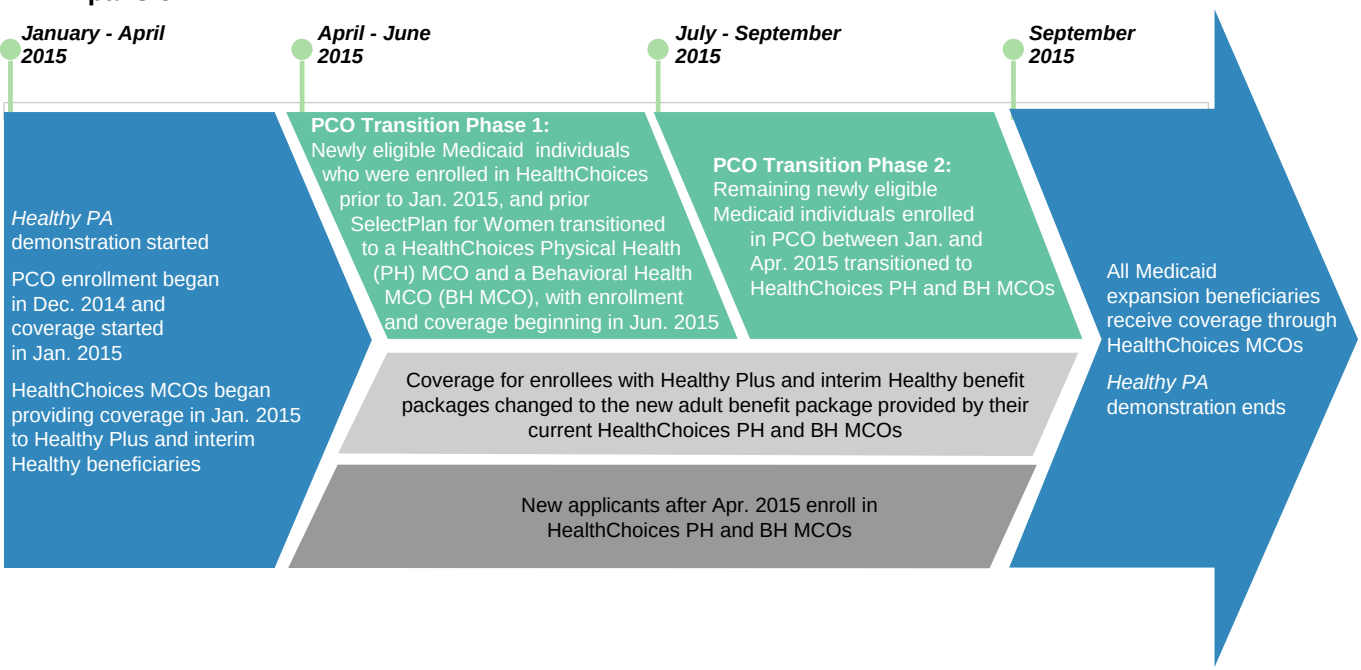


Figure Source: PA DHS. Medical Assistance Bulletin 99-15-05 with effective date April 28, 2015, Implementation of HealthChoices Medicaid Expansion. Retrieved from dhs.pa.gov: http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_172249.pdf.

2.4.2 Benefits Under HealthChoices Expansion

The new adult benefit package provided by HealthChoices complies with the Essential Health Benefits established under the ACA for newly Medicaid eligible adults and with federal parity requirements for behavioral health services.[4] Under HealthChoices expansion, no beneficiaries are charged premiums. See Section 8.6 in the Appendix for a detailed comparison of services and coverage limitations of services provided under the Medicaid State Plan and the Healthy PA waiver benefit packages, and the adult benefit package under HealthChoices Expansion.

2.4.3 Enrollees' Transition to HealthChoices Program

DHS transitioned Medicaid enrollees from Healthy PA to HealthChoices Expansion in two phases over a course of five months in April to June 2015 (phase 1) and July to August 2015 (phase 2) as depicted in Figure 4. Enrollees with Healthy and Healthy Plus benefit packages had their benefit packages changed to the new adult benefit package beginning in April 2015 (phase 1).[5] With the implementation of the new adult benefit package on April 27, 2015, individuals could receive additional Medicaid benefits that were not covered by their PCO package (e.g., non-emergency medical transportation and dental services) through DHS' fee-for-service (FFS) delivery system until their HealthChoices MCO coverage began.

Transition Phase 1 began on April 27, 2015, and involved 121,234 enrolled individuals.[6]

- Individuals enrolled in Healthy and Healthy Plus kept their current HealthChoices MCO, and the underlying benefit packages changed to the adult benefit package. Healthy and Healthy Plus benefit packages were discontinued on April 26, 2015.
- Individuals, who enrolled with a PCO plan effective January 1, 2015 but were previously covered under HealthChoices were transitioned to a HealthChoices Physical Health (PH) MCO and Behavioral Health (BH) MCO with enrollment beginning June 1, 2015. Individuals were automatically enrolled into the PH MCO affiliated with their PCO providing their Healthy PA coverage or their previous PH MCO if applicable. Individuals could choose to change plans once they received notification that they were moving from PCO to a PH MCO. These individuals received their health care coverage through their PCO plan through May 31, 2015.

[4] PA DHS. Medical Assistance Bulletin 99-15-05 with effective date April 28, 2015, *Implementation of* HealthChoices *Medicaid Expansion*. Retrieved from dhs.pa.gov: http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_172249.pdf.

[5] *Ibid.*

[6] Governor Tom Wolf's Press Release, Newsroom (April 27, 2015). *PA Transitions 121,234 into New Expanded Medicaid Program.* Retrieved from governor.pa.gov: https://www.governor.pa.gov/pennsylvania-transitions-new-expanded-medicaid-program/.

Additional Medicaid benefits not covered by their PCO health plan were offered through DHS' FFS delivery system in the meantime.

- Women who were previously eligible for SelectPlan for Women prior to January 1, 2015, who were determined eligible under traditional Medicaid or under the Medicaid expansion, were enrolled in HealthChoices PH and BH MCOs.
- Nonelderly adults newly qualified for Medicaid and Medicaid expansion were enrolled in HealthChoices PH MCOs and BH MCOs.

Transition Phase 2 began on July 28, 2015, for all remaining PCO enrollees (i.e., individuals who were enrolled with a PCO health plan between January and April 2015), who were transitioned to HealthChoices PH MCOs and BH MCOs effective September 1, 2015. At the beginning of Phase 2, nearly 137,800 individuals were still enrolled with a PCO plan. These individuals received their health care coverage through their PCO plans through August 31, 2015. Additional Medicaid benefits not covered by their PCO plans were covered by DHS' FFS delivery system.[7]

2.4.4 Advocates/Organizations Assisting with Outreach and Enrollment in Various Settings

In 2015, the federal government and private organizations provided additional support for outreach and enrollment in Pennsylvania's Medicaid and other health care programs. Six organizations received $3.1 million in navigator grant funds from the federal government to provide enrollment assistance to consumers in the Commonwealth: Consumer Health Coalition; Penn Asian Senior Services; Pennsylvania Association of Community Health Centers; Pennsylvania Mental Health Consumers' Association (PMHCA); Public Health Management Corporation; Young Women's Christian Association of Pittsburgh.[8]

DHS' outreach efforts included collaborating with community-, employment-, and faith-based organizations to reach the uninsured population. DHS focused HealthChoices marketing activities statewide, with a particular focus on minority populations who were uninsured, between the ages of 19 to 64 years old, and had an income up to 138% of the FPL. Outreach Service Reps (ORSs) were trained to educate the public about the

[7] *Ibid*.

[8] Centers for Medicare & Medicaid Services. *Center for Consumer Information and Insurance Oversight, 2013, 2014, and 2015 Navigator Grant Recipients*. Retrieved from CMS.gov: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/assistance.html.

HealthChoices program throughout the community. The goal of outreach was to increase HealthChoices enrollment by 600,000 by the end of June 2016.[9]

DHS selected a vendor to coordinate outreach and worked with approximately 400 organizations to become HealthChoices partner organizations. Partner organizations distributed HealthChoices materials, newsletters, and emails to constituents; participated in enrollment activities; and hosted community meetings and health fairs. The following table shows examples of the organizations that have been involved in the HealthChoices outreach and enrollment efforts.

Table 3. Examples of Outreach and Enrollment Efforts by Community Organizations and Affiliate Partners

Organizations and Partners	Approximate Reach	Outreach or Enrollment Activity
Grocery Store Connection*	75 stores distributed information 388,564 customers reached weekly	Provided information to customers by means of retail posters, bag stuffers, weekly store circular inserts, brochures, and pharmacy-supported receipt advertisements
HealthChoices in the News **	Four newsletters distributed to 1,285 organizations	Distributed newsletters throughout PA, including spotlight on Governor Wolf's initiative, "Medicaid 50", and "Healthy Harvest"
Events	48 events attended December 2014 through November 2015	Attended community, cultural, enrollment, and retail promotion events and health and job fairs
Breakfast with Faith-Based Leaders	More than 100 faith-based leaders attended	Engaged in roundtable discussion with DHS and 95% of those in attendance committed to the challenge of 100% health coverage in their congregations by the following year ***
Enroll America	Connections promoted application process assistance to thousands of individuals	Connected with local and regional governments, health centers, educational institutions, and small community organizations; assisted with application process
YMCAs	More than 4,500 copies of materials distributed	Collaborated with 23 local and regional YMCAs to reach a diverse population
Philadelphia Free Libraries	50 libraries in Philadelphia distributed more than 14,000 brochures	Distributed copies of English and Spanish flyers and brochures; resulted in additional outreach at other regional libraries
Central PA Food Bank	4,000 copies distributed 58,000 individuals reached weekly	Disseminated materials, promoted at events, leveraged network of partner organizations with e-blasts of HealthChoices newsletter

**Supermarkets and pharmacies included Foodland Supermarket, Giant Eagle, Shop 'N Save, Thriftway/Shop 'N Bag, Walgreens, and Weis Markets.*

[9] PA DHS. *HealthChoices Marketing Wrap-Up Report-Phase 1*. Provided by PA DHS on September 30, 2016 for purposes of this report.

***In addition, DHS has published at least six press releases on PA DHS HealthChoices' website: www.HealthChoicesPA.com and has provided additional mailings to consumers.*

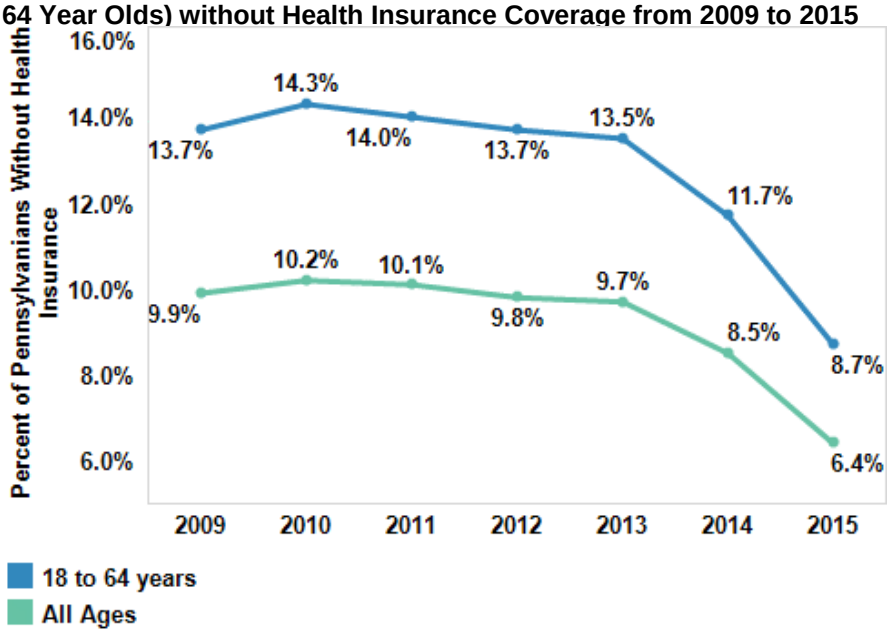
****The Spiritual Challenge was launched in February 2016. Fifteen (15) churches committed to provide assistance in helping 100% of their congregations to apply for a health care plan. An estimated 9,700 materials have been distributed by churches participating in the Spiritual Challenge. Copies of materials were customized for each church including: announcements and reminders; pastoral quotes and personalized letters; motivational, educational, social media, and Marquee messages; post-event reminders, website copy, web button, a Spanish-language promotional collateral and messaging, and pulpit scripting and mentions.*

Table Source: PA DHS. HealthChoices Marketing Wrap-Up Report-Phase 1. Provided by PA DHS on September 30, 2016 for purposes of this report.

2.5 Uninsured Rate in Pennsylvania Before and After Medicaid Expansion

According to the U.S. Census Bureau's American Community Survey (ACS), the uninsured rate in 2014 was 8.5% of all civilian and non-institutionalized Pennsylvanians of all ages (see Figure 5).[10] In 2015, Pennsylvania's uninsured rate decreased by more than two percentage points to 6.4% for all ages, becoming the 15th lowest in the U.S. The uninsured rate is 2.7 percentage points below the national average (9.1%). In states that expanded Medicaid eligibility, the uninsured rate in 2015 was 7.2%, compared

Figure 5. Percent of the Pennsylvania Population (All Ages, and 18 to 64 Year Olds) without Health Insurance Coverage from 2009 to 2015



U.S. Census Bureau. 2015 American Community Survey 1-Year Estimates. Retrieved from American Factfinder: https://factfinder.census.gov/.

[10] ACS surveys the civilian noninstitutionalized population, which excludes active-duty military personnel and the population living in correctional facilities and nursing homes. Health insurance coverage is defined as plans and programs that provide comprehensive health coverage. Plans that provide insurance for specific conditions or situations such as cancer, long-term care policies, dental, vision, life, and disability insurance are not considered health insurance coverage. People who had no reported health coverage, or those whose only health coverage was Indian Health Service, were considered uninsured. For reporting purposes, private health insurance is a plan provided through an employer or union, a plan purchased by an individual from a private company, or TRICARE or other military health care. Public health coverage includes the federal programs Medicare, Medicaid, and VA Health Care (provided through DHS of Veterans Affairs); CHIP; and individual state health plans. The types of health insurance are not mutually exclusive; more than one at the same time may cover an individual.

U.S. Census Bureau. *2015 American Community Survey 1-Year Estimates*. Retrieved from American Factfinder: https://factfinder.census.gov/.

For information on confidentiality protection, sampling error, nonsampling error, and definitions in the American Community Survey, see www2.census.gov/programs-surveys/acs/tech_docs/accuracy/ACS_Accuracy_of_Data_2015.pdf.

with 12.3% in states that did not expand Medicaid eligibility.

Medicaid expansion, combined with the availability of subsidized coverage on the Federal Marketplace, continued to help reduce Pennsylvania's uninsured rate. From 2009 to 2013, the U.S. Census Bureau estimated over 13.5% of nonelderly adults (18 to 64 years old) in Pennsylvania were uninsured. The percentage decreased to 11.7% in 2014, with approximately 916,000 nonelderly adult Pennsylvanians without health insurance coverage. The uninsured rate for nonelderly adults decreased by an additional three percentage points in 2015 to 8.7%.[11]

The following table compares uninsured statistics for nonelderly adults in 2014 and 2015 across all Pennsylvania counties using the ACS' 5-Year Estimates report.[12] The percentage of uninsured nonelderly adults in Pennsylvania between the ages of 18 and 64 years old decreased in all counties from 2014 to 2015, except for Lebanon and Snyder Counties. Wayne County had the greatest decrease of uninsured nonelderly adult Pennsylvanians, from 15.4% in 2014 to 12.5% in 2015.

Table 4. Uninsured Rates for Nonelderly Adults (18 to 64 years old) by County

County Name	Uninsured Percent for Nonelderly Adults in 2014	Uninsured Percent for Nonelderly Adults in 2015	Year-Over-Year Difference in Uninsured Percent for Nonelderly Adults
Adams	13.0%	11.4%	-1.6%
Allegheny	10.9%	9.9%	-1.0%
Armstrong	12.8%	12.3%	-0.5%
Beaver	11.1%	10.1%	-1.0%
Bedford	15.8%	14.7%	-1.1%
Berks	13.9%	12.9%	-1.0%
Blair	13.6%	11.8%	-1.8%
Bradford	16.0%	14.1%	-1.9%
Bucks	9.0%	8.5%	-0.5%
Butler	10.0%	8.8%	-1.2%
Cambria	11.8%	10.7%	-1.1%
Cameron	12.1%	9.5%	-2.6%
Carbon	15.7%	13.0%	-2.7%
Centre	8.3%	7.9%	-0.4%
Chester	10.8%	9.9%	-0.9%
Clarion	13.5%	12.8%	-0.7%
Clearfield	15.4%	13.4%	-2.0%

[11] *Ibid.*
[12] *Ibid.*

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County Name	Uninsured Percent for Nonelderly Adults in 2014	Uninsured Percent for Nonelderly Adults in 2015	Year-Over-Year Difference in Uninsured Percent for Nonelderly Adults
Clinton	13.2%	12.3%	-0.9%
Columbia	9.7%	9.2%	-0.5%
Crawford	17.2%	16.3%	-0.9%
Cumberland	9.7%	9.1%	-0.6%
Dauphin	13.5%	12.6%	-0.9%
Delaware	12.1%	11.0%	-1.1%
Elk	10.7%	9.8%	-0.9%
Erie	13.1%	11.8%	-1.3%
Fayette	15.8%	13.4%	-2.4%
Forest	16.5%	14.3%	-2.2%
Franklin	16.9%	16.2%	-0.7%
Fulton	14.8%	12.9%	-1.9%
Greene	12.7%	11.5%	-1.2%
Huntingdon	13.7%	12.5%	-1.2%
Indiana	14.0%	12.8%	-1.2%
Jefferson	15.3%	13.9%	-1.4%
Juniata	17.8%	16.9%	-0.9%
Lackawanna	12.9%	11.5%	-1.4%
Lancaster	15.2%	14.4%	-0.8%
Lawrence	13.2%	11.9%	-1.3%
Lebanon	14.8%	14.8%	0.0%
Lehigh	15.3%	14.4%	-0.9%
Luzerne	13.7%	12.4%	-1.3%
Lycoming	13.6%	12.2%	-1.4%
McKean	13.3%	11.6%	-1.7%
Mercer	12.8%	12.0%	-0.8%
Mifflin	18.5%	17.7%	-0.8%
Monroe	17.1%	15.9%	-1.2%
Montgomery	8.8%	8.1%	-0.7%
Montour	10.9%	9.8%	-1.1%
Northampton	12.0%	11.0%	-1.0%
Northumberland	15.1%	13.3%	-1.8%
Perry	14.7%	14.0%	-0.7%
Philadelphia	19.7%	18.2%	-1.5%
Pike	15.9%	14.3%	-1.6%
Potter	17.3%	15.2%	-2.1%

County Name	Uninsured Percent for Nonelderly Adults in 2014	Uninsured Percent for Nonelderly Adults in 2015	Year-Over-Year Difference in Uninsured Percent for Nonelderly Adults
Schuylkill	14.0%	13.0%	-1.0%
Snyder	16.4%	16.7%	+0.3%
Somerset	14.1%	12.7%	-1.4%
Sullivan	15.2%	14.6%	-0.6%
Susquehanna	17.4%	16.0%	-1.4%
Tioga	16.4%	15.4%	-1.0%
Union	13.7%	13.1%	-0.6%
Venango	14.3%	13.0%	-1.3%
Warren	13.0%	11.8%	-1.2%
Washington	11.1%	9.8%	-1.3%
Wayne	15.4%	12.5%	-2.9%
Westmoreland	10.3%	9.3%	-1.0%
Wyoming	13.6%	12.5%	-1.1%
York	12.6%	11.9%	-0.7%

Table Source: U.S. Census Bureau. 2015 American Community Survey 5-Year Estimates, S2701: Health Insurance Coverage Status. Retrieved from American Factfinder: https://factfinder.census.gov/.

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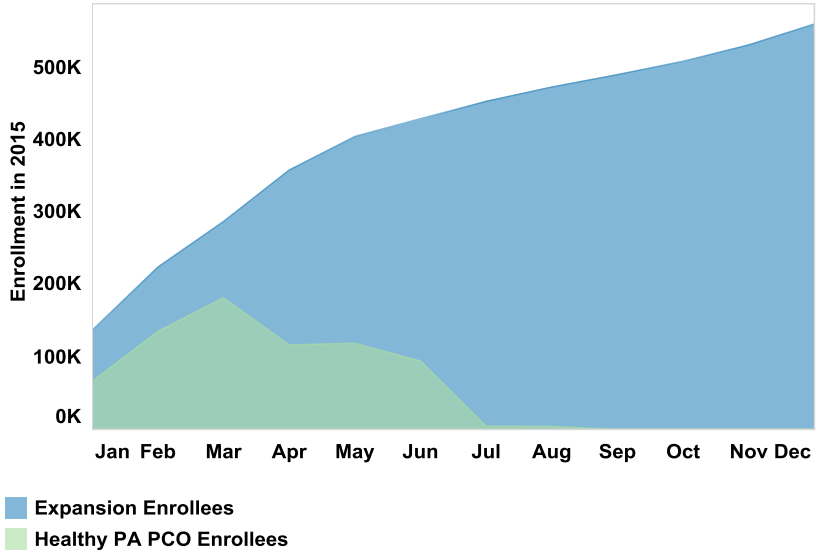
3. Enrollment Impact

3.1 Medicaid Expansion Enrollment

Newly eligible Medicaid expansion enrollment reached 559,851 by the end of December 2015. Figure 6 shows the enrollment rate of Medicaid expansion in terms of increases to monthly enrollment throughout CY 2015.[13] The monthly count was just over 100,000 newly eligible enrollees at the inception of Medicaid expansion in January 2015. PCO was discontinued by end of August 2015; PCO enrollees were transitioned to HealthChoices Expansion from April 2015 to September 2015.[14]

Figure 6. Medicaid Expansion Enrollment by Eligibility Category, Monthly Count throughout CY 2015



Newly eligible Medicaid expansion enrollment includes medical assistance categories MG 91 and PCO 91.

Individuals receiving Healthy PA PCO or PCO gap coverage who enrolled by December 2014 were transitioned into HealthChoices Expansion beginning on April 27, 2015 with their PCO coverage closing officially on May 31, 2015. Individuals in Healthy PA PCO or PCO gap coverage who enrolled after December 2014 were transitioned into HealthChoices Expansion beginning on July 27, 2015 with their PCO coverage closing officially on August 31, 2015.

Figure Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

Highlights

Medicaid Expansion Enrollment

- Medicaid expansion enrollment reached 559,851,000 individuals by the end of CY 2015
- Over 11% of nonelderly adults (19 to 64 year olds) residing in Cameron, Delaware, Fayette, Forest and Philadelphia Counties were enrolled in Medicaid expansion by December 2015
- Expansion enrollment accounted for 18.1% of Medicaid enrollees in CY 2015

Total Medicaid Enrollment

- Statewide Medicaid enrollment increased by 13.8% from CY 2014 levels and reached over 2.6 million enrollees by the end of CY 2015
- 21% of Pennsylvania's population was enrolled in Medicaid in CY 2015

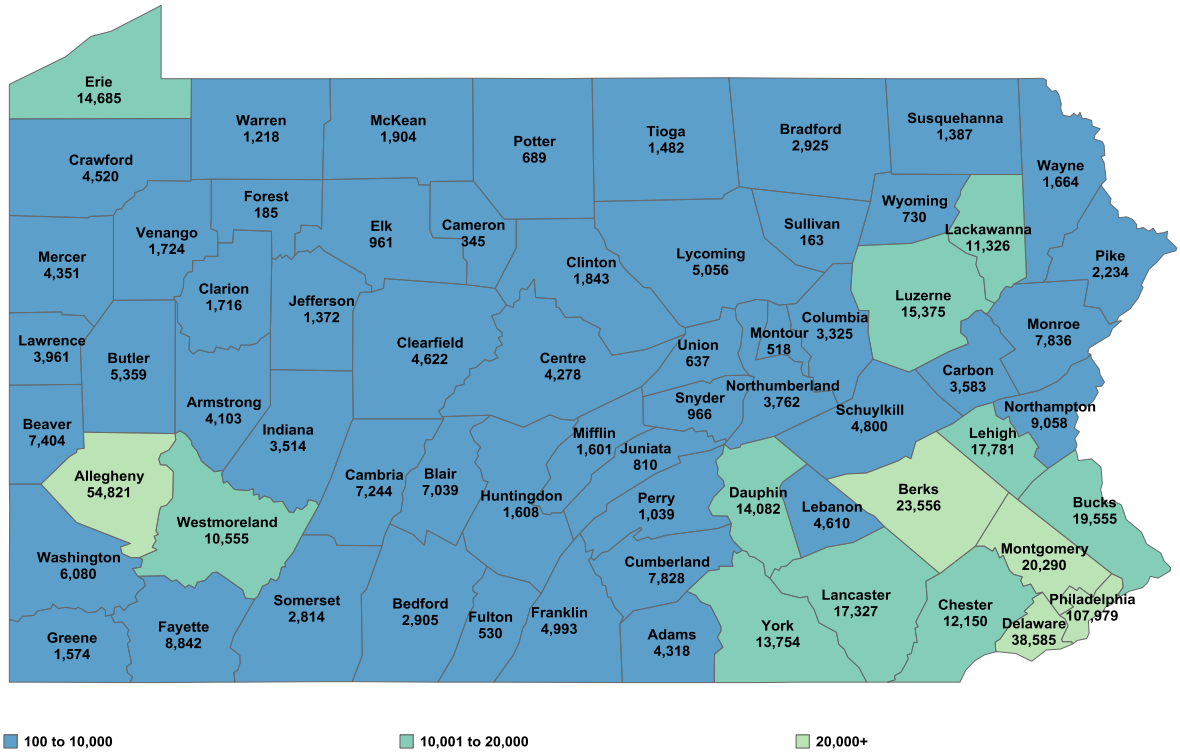
[13] PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

[14] PA DHS. Medical Assistance Bulletin 99-15-05 with effective date April 28, 2015, *Implementation of HealthChoices Medicaid Expansion*. Retrieved from dhs.pa.gov: http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_172249.pdf.

3.1.1 Medicaid Expansion Enrollment by County

Residents from each county of Pennsylvania have been able to obtain access to health care through Medicaid expansion. The map in Figure 7 identifies the count of newly eligible Medicaid expansion enrollees by county in December 2015. Nineteen percent (19%) of newly eligible enrollees resided in Philadelphia County, and another 10% resided in Allegheny County. Fifteen (15) counties had 10,000 or more newly eligible Medicaid expansion enrollees in the end of December 2015.

Figure 7. Medicaid Expansion Enrollment in December 2015 by County



Newly eligible Medicaid expansion enrollment includes medical assistance categories MG 91 in December 2015.
Figure Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

Statewide, over 7% of nonelderly adults in Pennsylvania were enrolled in Medicaid expansion by December 2015. The table below provides the percentage of each county's nonelderly adult population enrolled in Medicaid expansion in 2015. Over 11% of nonelderly adults in 2015 residing in Cameron, Delaware, Fayette, Forest and Philadelphia Counties were enrolled in Medicaid expansion by December 2015.

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Table 5. Medicaid Expansion Enrollment (as of December 2015) as a Percentage of the Nonelderly Adult Population by County

County Name	Medicaid Expansion Enrollment as of Dec. 31, 2015 (19 to 64 Years Old)	Nonelderly Adult Population in 2015 (18 to 64 Years Old)	% of Nonelderly Adult Enrolled in Medicaid Expansion
Adams	4,318	61,980	7%
Allegheny	54,821	777,849	7%
Armstrong	4,103	40,774	10%
Beaver	7,404	102,689	7%
Bedford	2,905	28,774	10%
Berks	23,556	252,358	9%
Blair	7,039	76,181	9%
Bradford	2,925	36,471	8%
Bucks	19,555	386,529	5%
Butler	5,359	114,981	5%
Cambria	7,244	81,213	9%
Cameron	345	2,874	12%
Carbon	3,583	39,046	9%
Centre	4,278	111,358	4%
Chester	12,150	314,662	4%
Clarion	1,716	24,982	7%
Clearfield	4,622	46,207	10%
Clinton	1,843	24,405	8%
Columbia	3,325	43,303	8%
Crawford	4,520	51,711	9%
Cumberland	7,828	147,350	5%
Dauphin	14,082	167,551	8%
Delaware	38,585	347,680	11%
Elk	961	18,673	5%
Erie	14,685	171,805	9%
Fayette	8,842	80,279	11%
Forest	185	1,736	11%
Franklin	4,993	89,373	6%
Fulton	530	8,692	6%
Greene	1,574	21,199	7%
Huntingdon	1,608	25,277	6%
Indiana	3,514	56,079	6%
Jefferson	1,372	26,511	5%
Juniata	810	14,355	6%
Lackawanna	11,326	129,589	9%

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County Name	Medicaid Expansion Enrollment as of Dec. 31, 2015 (19 to 64 Years Old)	Nonelderly Adult Population in 2015 (18 to 64 Years Old)	% of Nonelderly Adult Enrolled in Medicaid Expansion
Lancaster	17,327	314,250	6%
Lawrence	3,961	53,102	7%
Lebanon	4,610	80,024	6%
Lehigh	17,781	217,540	8%
Luzerne	15,375	192,403	8%
Lycoming	5,056	70,370	7%
McKean	1,904	25,034	8%
Mercer	4,351	66,981	6%
Mifflin	1,601	26,715	6%
Monroe	7,836	106,731	7%
Montgomery	20,290	495,744	4%
Montour	518	10,813	5%
Northampton	9,058	185,535	5%
Northumberland	3,762	54,100	7%
Perry	1,039	28,380	4%
Philadelphia	107,979	1,010,594	11%
Pike	2,234	33,507	7%
Potter	689	9,856	7%
Schuylkill	4,800	84,613	6%
Snyder	966	24,629	4%
Somerset	2,814	43,329	6%
Sullivan	163	3,780	4%
Susquehanna	1,387	25,573	5%
Tioga	1,482	25,559	6%
Union	637	24,471	3%
Venango	1,724	32,057	5%
Warren	1,218	24,229	5%
Washington	6,080	127,603	5%
Wayne	1,664	28,835	6%
Westmoreland	10,555	217,553	5%
Wyoming	730	17,247	4%
York	13,754	269,546	5%

Newly eligible Medicaid expansion enrollment, age 19 to 64 years olds, includes medical assistance categories MG 91 and PCO 91. American Community Survey reports the uninsured rate for 18 to 64 years old.

Table Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

U.S. Census Bureau. 2015 American Community Survey 5-Year Estimates. Counties' Total Population retrieved from American Factfinder: https://factfinder.census.gov/.

3.2 Growth in Medicaid Enrollment as a Result of Medicaid Expansion

Medicaid expansion has had a substantial impact on the number of individuals enrolled in Pennsylvania's Medicaid program. The table below represents the portion of the Commonwealth's population enrolled in Medicaid in CYs 2011 to 2015. From CY 2011 to CY 2014, Medicaid enrollment equaled an estimated 18% of the population in Pennsylvania. Twenty-one percent (21%) of the population in Pennsylvania was enrolled in Medicaid by the end of CY 2015, the first year of Medicaid expansion.[15]

Table 6. Percentage of Pennsylvania's Population Enrolled in Medicaid from CY 2011 to CY 2015

Calendar Year (CY)	Total Medicaid Enrollees	Total Population (all ages)	Percent of Population Enrolled in Medicaid
CY 2011	2,231,188	12,539,757	18%
CY 2012	2,236,951	12,559,315	18%
CY 2013	2,241,497	12,569,375	18%
CY 2014	2,286,431	12,582,815	18%
CY 2015	2,602,539	12,599,417	21%

Table Sources: PA DHS. Average monthly unduplicated count of Medicaid enrollees by Calendar Year calculated from 'Monthly Eligibility from Data Warehouse - September 2016.xlsx' provided by DHS on October 25, 2016 for the purposes of this report.

Total Civilian Noninstitutionalized Population (all ages) retrieved from U.S. Census Bureau. 2015 American Community Survey 1-Year Estimates, available from American Factfinder: https://factfinder.census.gov/.

3.2.1 Medicaid Enrollment by Calendar Year

Prior to Medicaid expansion, from CY 2011 to 2014, the average monthly Medicaid enrollment remained relatively constant at 2.2 million enrolled individuals. Enrollment increased with the expansion of Medicaid eligibility in CY 2015 to a monthly average of 2.6 million, representing a 14% increase from prior years' levels, as depicted in Figure 8.[16] Monthly average enrollment increased from 2.28 million in CY 2014 to 2.60 million in CY 2015.[17] Medicaid expansion introduced new categories of eligibility for federal claiming and reporting purposes, which are depicted as "Medicaid Expansion Enrollees" in Figure 8. The decline in "All Other Medicaid Enrollees" in CY 2015 is partially due to

[15] Calculated using monthly Medicaid enrollment from PA DHS. *'Monthly Eligibility from Data Warehouse – September 2016.xlsx'* provided by DHS on October 25, 2016 and U.S. Census Bureau, 2015 American Community Survey 1-year Estimates. Retrieved from American Factfinder. https://factfinder.census.gov/.

[16] The unduplicated count of Medicaid enrollees was 2,286,431 in CY 2014 and was 2,602,539 in CY 2015.

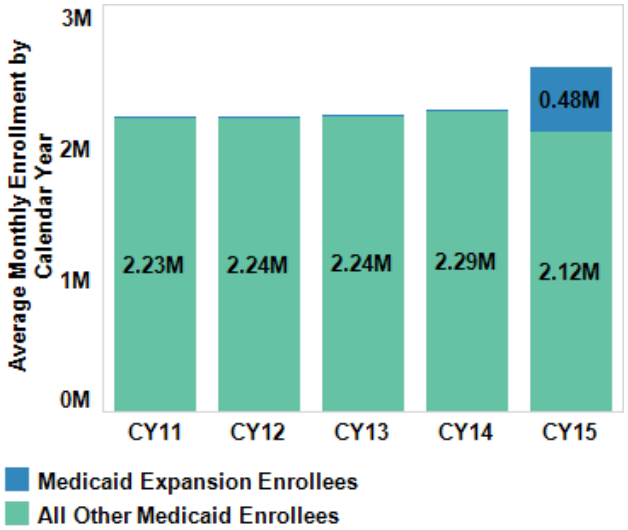
PA DHS. Retrieved from 'Monthly Eligibility from Data Warehouse - September 2016.xlsx' provided by DHS on October 25, 2016 for the purposes of this report.

[17] *Ibid.*

the re-categorization of existing Medicaid enrollees into Medicaid expansion categories of eligibility. Medicaid expansion accounted for 18.1% of the total Medicaid enrollment.

Pennsylvania's enrollment increase was similar to that of other states that expanded Medicaid eligibility, which saw average enrollment increases of 18.0% according to the Kaiser Family Foundation.[18] Section 8.3 in the Appendix shows statewide Medicaid enrollment for the past five years, both on a calendar year and state fiscal year basis.

Figure 8. Medicaid Enrollment by Calendar Year, Average Monthly Count in Millions



Medicaid expansion enrollees of 0.48 million is the average monthly count throughout CY 2015. The count of expansion enrollees reached 0.62 million in December 2015.

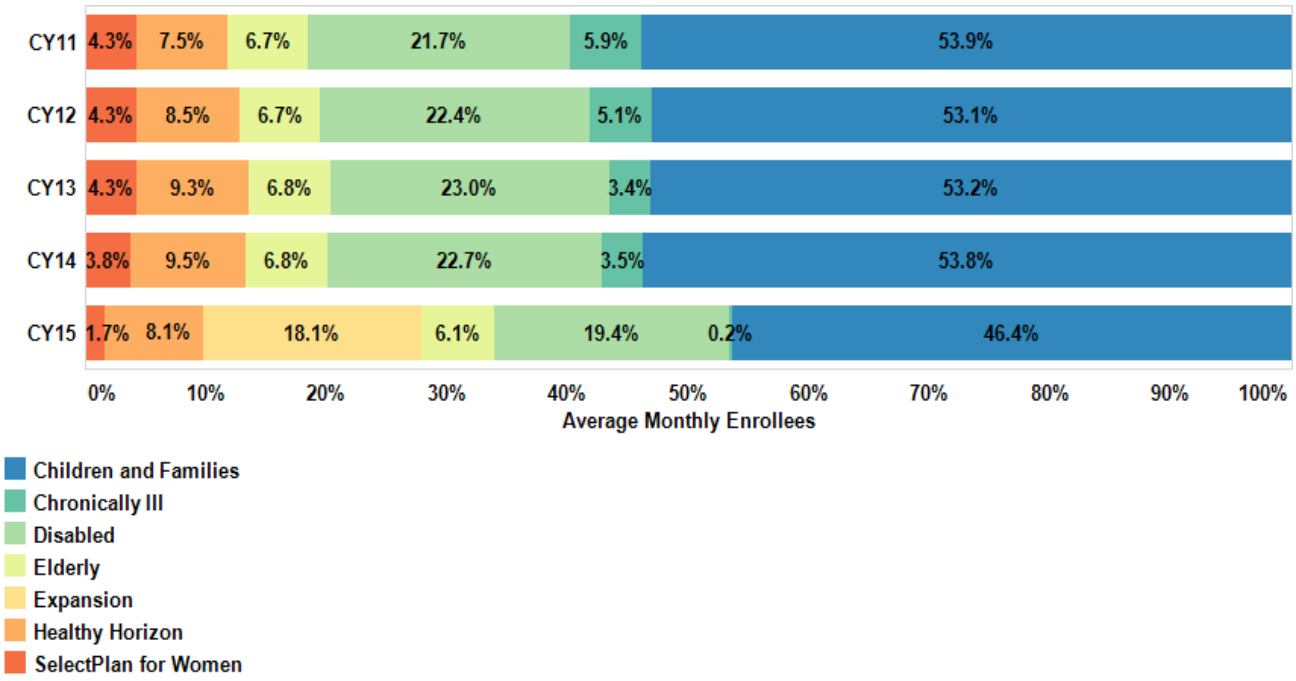
Figure Source: PA DHS. Retrieved from 'Monthly Eligibility from Data Warehouse - September 2016.xlsx' provided by DHS on October 25, 2016 for the purposes of this report.

[18] Medicaid Enrollment and spending Growth: FY2015 and 2016 Issue Brief, October 2015. Retrieved from http://kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2015-2016/.

3.2.2 Medicaid Enrollment by Eligibility Category

The following figure compares Medicaid enrollment by eligibility category in CY 2015 to that of the four previous years.[19] The majority of Medicaid enrollees were historically children and families, individuals with disabilities, and the elderly.[20] In CY 2015, Medicaid expansion extended health care coverage to adults under new categories of eligibility, which are depicted in the following figure. Expansion enrollees accounted for 18.1% of total Medicaid enrollment in CY 2015. Section 8.3 in the Appendix shows statewide Medicaid enrollment for the past five years.

Figure 9. Distribution of Average Monthly Medicaid Enrollment by Eligibility Category during CYs 2011 to 2015



The duplicated Medicaid enrollment count was 2,231,188 in CY2011; 2,236,951 in CY2012; 2,241,497 in CY2013; 2,286,431 in CY2014; and 2,602,539 in CY2015.

Figure Source: PA DHS. Retrieved from 'Monthly Eligibility from Data Warehouse - September 2016.xlsx' provided by DHS on October 25, 2016 for the purposes of this report.

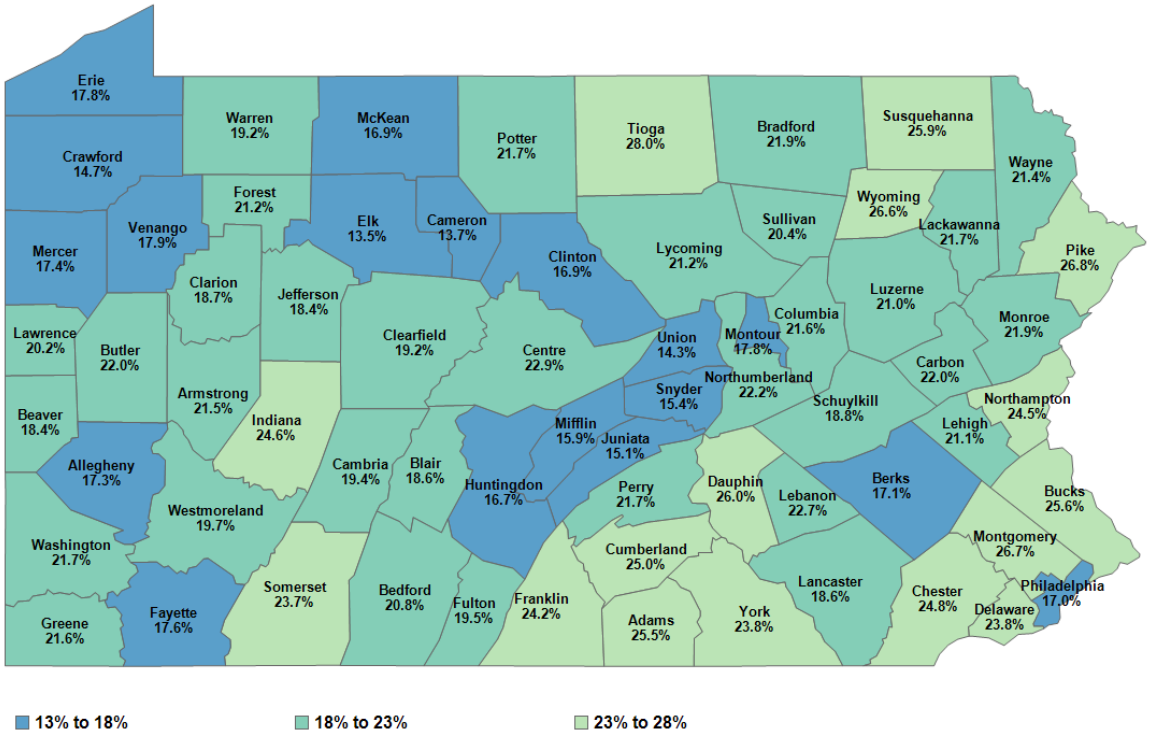
[19] PA DHS. Retrieved from 'Monthly Eligibility from Data Warehouse - September 2016.xlsx' provided by DHS on October 25, 2016 for the purposes of this report.

[20] Eligibility for some enrollees under the Children and Families category should have started January 1, 2015, but some were entered into the system with a start date of December 1, 2014. As of July 1, 2015, SelectPlan for Women participants (who were not otherwise eligible for Medicaid) were covered under the Family Planning Services program. The decrease in SelectPlan for Women enrollment was primarily a result of the Family Planning Service coverage.

3.2.3 Medicaid Enrollment by County

Between December 2014 and 2015, all Pennsylvania counties experienced an increase in Medicaid enrollment, ranging from 14% to 28%. Section 8.4 in the Appendix includes tables with the monthly Medicaid enrollment by county and by month, from July 2014 to July 2016. Figure 10 below illustrates Medicaid enrollment growth by county between December 2014 and December 2015.[21] Tioga County had the largest percent increase in Medicaid enrollment from 7,009 enrollees in 2014 to 8,971 enrollees in 2015 (28% or 1,962 additional enrollees). Elk County experienced the smallest growth in Medicaid enrollment from 5,105 in 2014 to 5,795 enrollees in 2015 (14% or 690 additional enrollees).

Figure 10. Difference in Medicaid Enrollment from December 2014 to December 2015 by County



The percent change in Medicaid enrolled individuals between December 2014 and December 2015.

Figure Source: PA DHS. DHS' Medical Assistance, Food Stamps and Cash Assistance statistics report, April 2016 data as of May 10, 2016. The percent change in Medicaid enrolled individuals between December 2014 and December 2015 calculated from http://listserv.dpw.state.pa.us/Scripts/wa.exe?A1=ind16&L=ma-food-stamps-and-cash-stats.

[21] The percent change in Medicaid enrolled individuals between December 2014 and December 2015. PA DHS. DHS' Medical Assistance, Food Stamps and Cash Assistance statistics report, April 2016 data as of May 10, 2016. Calculated from http://listserv.dpw.state.pa.us/Scripts/wa.exe?A1=ind16&L=ma-food-stamps-and-cash-stats.

By December 2015, Pennsylvania's counties had between 9% and 40% of their population enrolled in Medicaid. The map in Figure 11 identifies the percentage of each county's population enrolled in Medicaid at the end of December 2015. By the end of CY 2015, over 30% of residents in Fayette, Forest, and Philadelphia Counties were enrolled in Medicaid.

Figure 11. Percentage of Pennsylvania Counties' Population Enrolled in Medicaid (as of December 2015)

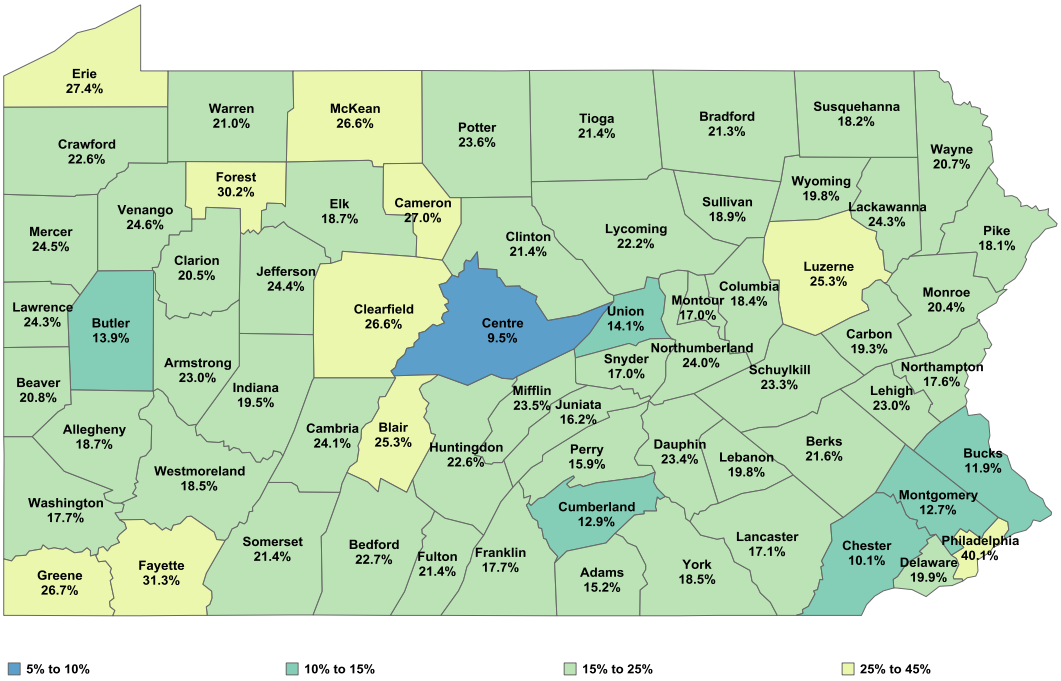


Figure Sources: PA DHS. Medicaid enrollment calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

U.S. Census Bureau. American Community Survey 5-Year Estimates, 2014 and 2015. Counties' Total Population retrieved from American Factfinder: https://factfinder.census.gov/.

The following table compares Medicaid enrollment in 2014 to 2015 as a percentage of total population for all counties in Pennsylvania.

Table 7. Percentage of Pennsylvania Counties' Population Enrolled in Medicaid in 2014 and 2015

	2014			2015		
County Name	Medicaid Enrollment as of Dec. 2014	Total Population in 2014	Percent of Population Enrolled in Medicaid in 2014	Medicaid Enrollment as of Dec. 2015	Total Population in 2015	Percent of Population Enrolled in Medicaid in 2015
Adams	12,145	100,245	12%	15,241	100,449	15%
Allegheny	193,875	1,214,370	16%	227,382	1,217,037	19%

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	2014			2015		
County Name	Medicaid Enrollment as of Dec. 2014	Total Population in 2014	Percent of Population Enrolled in Medicaid in 2014	Medicaid Enrollment as of Dec. 2015	Total Population in 2015	Percent of Population Enrolled in Medicaid in 2015
Armstrong	12,783	67,808	19%	15,529	67,441	23%
Beaver	29,634	168,629	18%	35,074	168,481	21%
Bedford	9,123	48,771	19%	11,023	48,542	23%
Berks	75,357	408,084	18%	88,242	409,151	22%
Blair	26,678	124,952	21%	31,649	124,863	25%
Bradford	10,773	61,883	17%	13,135	61,608	21%
Bucks	59,000	620,253	10%	74,088	620,447	12%
Butler	20,856	182,796	11%	25,450	183,650	14%
Cambria	27,221	136,141	20%	32,505	134,825	24%
Cameron	1,145	4,888	23%	1,302	4,824	27%
Carbon	10,106	64,098	16%	12,325	63,824	19%
Centre	11,882	153,263	8%	14,602	154,387	9%
Chester	40,959	501,508	8%	51,127	504,927	10%
Clarion	6,730	39,023	17%	7,991	39,031	20%
Clearfield	16,957	76,508	22%	20,221	75,991	27%
Clinton	7,142	38,984	18%	8,349	39,007	21%
Columbia	10,018	66,328	15%	12,177	66,142	18%
Crawford	16,892	86,102	20%	19,367	85,757	23%
Cumberland	24,293	233,159	10%	30,365	235,088	13%
Dauphin	49,715	266,222	19%	62,634	267,726	23%
Delaware	89,119	553,107	16%	110,353	554,295	20%
Elk	5,105	31,259	16%	5,795	31,047	19%
Erie	63,754	274,824	23%	75,118	274,610	27%
Fayette	34,987	132,105	26%	41,162	131,487	31%
Forest	913	4,289	21%	1,107	3,669	30%
Franklin	21,535	149,996	14%	26,744	150,972	18%
Fulton	2,626	14,700	18%	3,137	14,650	21%
Greene	7,573	34,788	22%	9,211	34,534	27%
Huntingdon	8,158	42,140	19%	9,519	42,051	23%
Indiana	13,526	86,771	16%	16,852	86,342	20%
Jefferson	9,125	44,425	21%	10,805	44,211	24%
Juniata	3,467	24,502	14%	3,990	24,561	16%
Lackawanna	41,830	210,433	20%	50,892	209,690	24%
Lancaster	75,323	519,889	14%	89,347	523,210	17%

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	2014			2015		
County Name	Medicaid Enrollment as of Dec. 2014	Total Population in 2014	Percent of Population Enrolled in Medicaid in 2014	Medicaid Enrollment as of Dec. 2015	Total Population in 2015	Percent of Population Enrolled in Medicaid in 2015
Lawrence	17,797	88,781	20%	21,388	88,121	24%
Lebanon	21,611	133,422	16%	26,522	134,099	20%
Lehigh	66,969	349,844	19%	81,084	351,921	23%
Luzerne	65,285	312,864	21%	79,007	312,373	25%
Lycoming	20,782	113,719	18%	25,194	113,522	22%
McKean	9,293	40,901	23%	10,859	40,779	27%
Mercer	23,199	111,967	21%	27,243	111,383	24%
Mifflin	9,335	46,167	20%	10,821	46,117	23%
Monroe	27,978	167,279	17%	34,108	166,883	20%
Montgomery	80,147	796,362	10%	101,517	799,584	13%
Montour	2,581	17,899	14%	3,040	17,899	17%
Northampton	42,025	295,996	14%	52,315	296,646	18%
Northumberland	17,591	89,961	20%	21,491	89,465	24%
Perry	5,882	45,289	13%	7,161	45,172	16%
Philadelphia	528,758	1,531,799	35%	618,386	1,540,765	40%
Pike	8,011	56,480	14%	10,155	56,218	18%
Potter	3,327	17,225	19%	4,048	17,146	24%
Schuylkill	27,425	140,430	20%	32,587	139,640	23%
Snyder	5,853	39,590	15%	6,755	39,724	17%
Somerset	12,460	72,613	17%	15,419	71,889	21%
Sullivan	972	6,224	16%	1,170	6,191	19%
Susquehanna	6,067	42,355	14%	7,641	42,064	18%
Tioga	7,009	41,923	17%	8,971	41,871	21%
Union	4,864	39,458	12%	5,561	39,395	14%
Venango	11,092	53,495	21%	13,072	53,146	25%
Warren	7,077	40,496	17%	8,437	40,254	21%
Washington	30,060	206,424	15%	36,569	206,574	18%
Wayne	8,189	48,448	17%	9,941	48,062	21%
Westmoreland	55,065	358,183	15%	65,935	356,931	18%
Wyoming	4,360	27,912	16%	5,519	27,903	20%
York	64,919	433,218	15%	80,386	434,824	18%

Table Sources: Calculated from PA DHS. DHS' Medical Assistance, Food Stamps and Cash Assistance statistics report, April 2016 data as of May 10, 2016. Medicaid enrolled individuals in December 2015 retrieved from http://listserv.dpw.state.pa.us/Scripts/wa.exe?A1=ind16&L=ma-food-stamps-and-cash-stats.

U.S. Census Bureau. American Community Survey 5-Year Estimates, 2014 and 2015. *Counties' Total Population from S2701: Health Insurance Coverage Status. Retrieved from American Factfinder: https://factfinder.census.gov/.*

4. State Budget Impact

4.1 Total Medicaid Expenditures

Almost $1 of every $4 of the Commonwealth's annual budget is spent on Medicaid. The program itself is funded by a combination of state and federal dollars. Figure 12 shows the relative State General Fund expenditures by category, in State Fiscal Year (SFY) 2012-2013, SFY 2013-2014, SFY 2014-2015 compared to the recent SFY 2015-2016.[22] State General Fund Medicaid expenditures averaged $28.7 billion annually. [23] Medicaid as a percent of State General Fund expenditures remained relatively constant at 23% during the same period. Medicaid expenditures were second only to expenditures related to primary and secondary education.[24]

Highlights

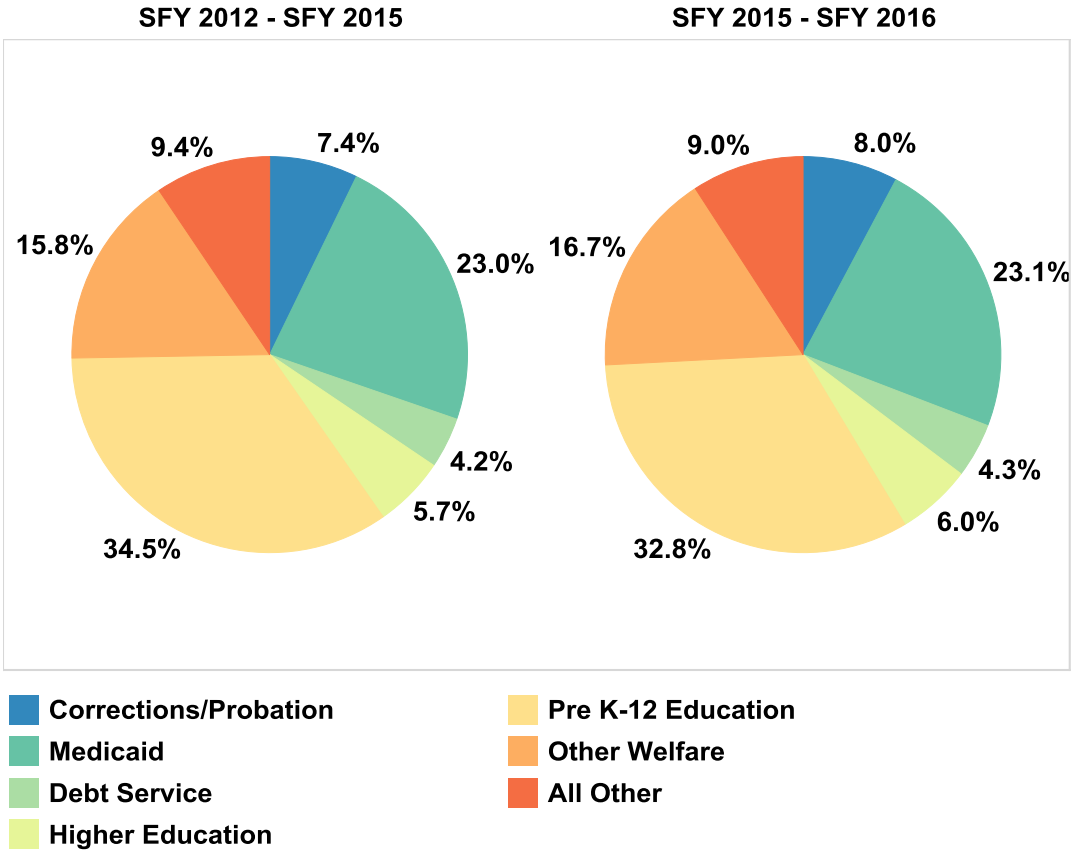
- The state's share of Medicaid expenditures held relatively steady for the first time in four years, from $10.5 billion in CY 2014 to $10.6 billion in CY 2015
- The federal government covered 100% of the costs for newly eligible Medicaid expansion members through CY 2016
- Service expenditures for Medicaid expansion were approximately $2.76 billion in CY 2015 (state and federal funds) and represented approximately 11% of the total Medicaid service expenditures

[22] SFYs span from July 1 to June 30. For example, SFY 2015-2016 spans from July 1, 2015 to June 30, 2016.

[23] Pennsylvania Office of the Budget. Past Budgets 2015-16 to 2006-07. Retrieved from budget.pa.gov: http://www.budget.pa.gov/PublicationsAndReports/CommonwealthBudget/Pages/PastBudgets2015-16To2006-07.aspx.

[24] *Ibid.*

Figure 12. State General Fund Expenditures by Category for SFYs 2012-2015 and SFY 2015-2016



Percentages are approximate due to rounding. Data provided by the Office of the Budget is by State Fiscal Years and was not adjusted to Calendar Years for the purposes of this report. SFY 2015-2016, for example, refers to the State Fiscal Year starting in July 2015 and ending in June 2016. Average expenditures during SFYs 2012-2015 (average of SFY 2012-2013, SFY 2013-2014, SFY 2014-2015) on the left is compared to the recent SFY 2015-2016 on the right.

Figure Source: Pennsylvania Office of the Budget. Past Budgets State Fiscal Years 2006-07 to 2015-16. Retrieved from pa.gov: http://www.budget.pa.gov/PublicationsAndReports/CommonwealthBudget/Pages/PastBudgets2015-16To2006-07.aspx.

4.2 Federal and State Share of Medicaid Expansion Expenditures

Total expenditures (federal and state dollars) for Pennsylvania's Medicaid program have increased over the past five calendar years. Figure 13 shows the federal and state share of Pennsylvania's total Medicaid expenditures from CYs 2011 to 2015. Between CY 2011 and 2014, the state share of Medicaid expenditures rose on average 9% each year; however, in CY 2015, the state share of Medicaid expenditures rose by only approximately 1%, from $10.5 billion in CY 2014 to $10.6 billion in CY 2015.[25]

[25] PA DHS. Total Medicaid service expenditures prepared for CMS 64 and provided by DHS on October 20, 2016 for the purposes of this report.

Figure 13. Medicaid Services Expenditures by Federal and State Share from CY 2011 to CY 2015

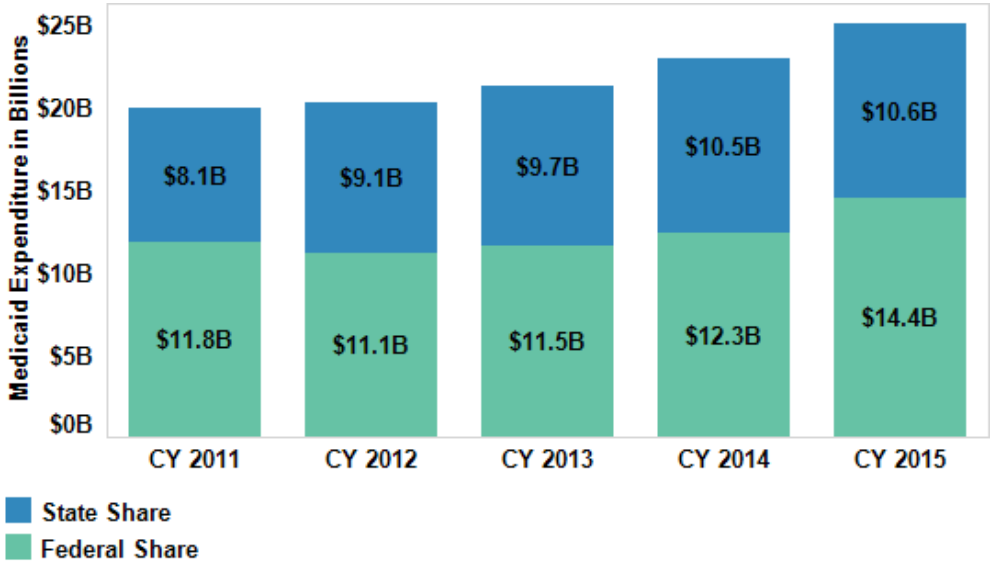


Figure Source: PA DHS. Total Medicaid service expenditures for CMS 64 provided by DHS on October 20, 2016, and adjusted to calendar year periods for the purposes of this report.

The Federal Medical Assistance Percentage (FMAP) specifies the portion of Medicaid expenditures that the federal government contributes to Pennsylvania's Medicaid program annually. As seen in Table 8, in Federal Fiscal Year (FFY) 2015 from October 1, 2014 to September 30, 2015, the federal government provided Pennsylvania with a FMAP of 51.82%, meaning the federal government covered approximately 52 cents of every dollar spent on Medicaid in Pennsylvania. This federal match rate is determined based on income per capita on a state-by-state basis, and changes annually.

Table 8. Pennsylvania Regular FMAP by FFY

Time Period by Federal Fiscal Year (FFY)	FMAP
October 1, 2011 to September 30, 2012 (FFY 2012)	55.07%
October 1, 2012 to September 30, 2013 (FFY 2013)	54.28%
October 1, 2013 to September 30, 2014 (FFY 2014)	53.52%
October 1, 2014 to September 30, 2015 (FFY 2015)	51.82%
October 1, 2015 to September 30, 2016 (FFY 2016)	52.01%

Table Source: U.S. Department of Health & Human Services (DHHS). Federal Medical Assistance Percentage (FMAP) or Federal Financial Participation in State Assistance Expenditures. Retrieved from https://aspe.hhs.gov/federal-medical-assistance-percentages-or-federal-financial-participation-state-assistance-expenditures.

The ACA authorizes increased federal funding for Medicaid expansion by granting two types of increased federal match rates—the newly eligible FMAP and the expansion state FMAP. The newly eligible FMAP is available for state Medicaid expenditures on

behalf of newly eligible individuals, who are between the ages of 19 and 64 years, and who would not have been eligible for Medicaid in the state as of December 1, 2009 or were eligible under a waiver but not enrolled because of limits or caps on waiver enrollment. The newly eligible FMAP covers 100% of the service costs for newly eligible Medicaid expansion enrollees for CY 2015 and CY 2016 and then phases down gradually to 90% of costs by 2020. Pennsylvania's newly eligible Medicaid expansion enrollees (i.e., medical assistance categories MG 91 and PCO 91) includes the following types of individuals whose income is at or below threshold to 138% of the FPL under the MAGI methodology and with up to 5% of their income disregarded.

- Individuals made newly eligible for Medicaid under the ACA whose income is less than or equal to 138% of the FPL.
- Non-disabled childless adults age 21 to 64 years old and income at or below 138% FPL
- Individuals age 19 to 20 years old with income at or between 44% to 138% FPL
- Adults with permanent disabilities, age 21 to 64 years old with a disability not verified by the Social Security Administration (SSA) or Medical Review Team (MRT), with no Medicare, and income at or below 138% FPL
- Adults with permanent disabilities, age 21 to 64 years old with a disability verified by the SSA or MRT, with no Medicare, and income at or between 102% to 138% FPL
- Non-disabled parents/caretakers age 21 to 64 years old with income at or between 33% to 138% of the FPL

Prior to Medicaid expansion, some of these individuals were eligible for Medically Needy Only Medical Assistance (MNO) or General Assistance (GA) Medical Assistance programs.[26]

The expansion state FMAP is an alternate increased FMAP available to match state expenditures in states that expanded Medicaid eligibility, prior to the ACA, for parents/caretakers and adults without dependent children with an income up to 100% of the FPL (under either the State Plan or a demonstration project).[27] The federal match for these Medicaid expansion enrollees increases until CY 2019 when the federal match reaches the same level as that for newly eligible Medicaid expansion enrollees.

[26] PA DHS, Office of Income Maintenance. *Expansion and FMAP Categories* reference sheet. Provided on August 25, 2016 for the purposes of this report.

[27] U.S. Centers of Medicare & Medicaid Services (CMS). Newly Eligible and Expansion State FMAP FAQs, released February 2013, retrieved from Medicaid.gov.

Pennsylvania's traditionally eligible groups, for which the federal government provided enhanced funding through Medicaid expansion in CY 2015, includes the following.[28]

- Individuals age 19 to 20 years old whose income is at or below 44% FPL, either without disabilities or with permanent disabilities (MRT/SSA verified or not MRT/SSA verified), and with no Medicare (i.e., medical assistance category MG 90 N)
- Individuals age 19 to 64 years old with permanent disability, who are parents/ caretakers, do not have Medicare, and whose income is between 33% and 102% of the FPL (i.e., medical assistance category MG 90 D)
- Individuals age 19 to 64 years old with permanent disability, who are not parents/ caretakers, do not have Medicare, and whose income is up to 102% of the FPL (i.e., medical assistance category MG 90 D)
- Inmates of State Correctional Institutions or County Correctional facilities with exceptions (i.e., medical assistance categories MG 38 and MG 39), effective March 2016

The following table identifies the special FMAPs for Pennsylvania enacted by the ACA.

Table 9. Pennsylvania Special FMAPs for Medicaid Expansion Categories of Eligibility under the ACA during CY 2015 to 2020

Calendar Year	Special Federal Match for Newly Eligible (newly eligible FMAP)	Special Federal Match as an Expansion State, Blended (expansion state FMAP)
CY 2015	100%	80.7%
CY 2016	100%	85.6%
CY 2017	95%	86.4%
CY 2018	94%	89.8%
CY 2019	93%	93%
CY 2020 and beyond	90%	90%

*The formula used to calculate expansion state FMAP is [regular FMAP + (newly eligible federal matching rate – regular FMAP) * transition percentage]. The transition percentage is equal to 60% in CY2015, 70% in CY2016, 80% in CY2017, 90% in CY2018, and 100% in CY2019. Since the formula is based on the regular FMAP rate, the expansion state FMAP will vary based on the Commonwealth's regular FMAP rates until CY2019, at which point the match rate will equal the newly eligible FMAP.*

Table Source: Congressional Research Service: Medicaid's Federal Medical Assistance Percentage (FMAP) Referenced from fas.org: https://www.fas.org/sgp/crs/misc/R43847.pdf.

PA DHS. Blended Federal Match for Not Newly Eligible (as an Expansion State), provided by DHS on January 3, 2017 for the purposes of this report.

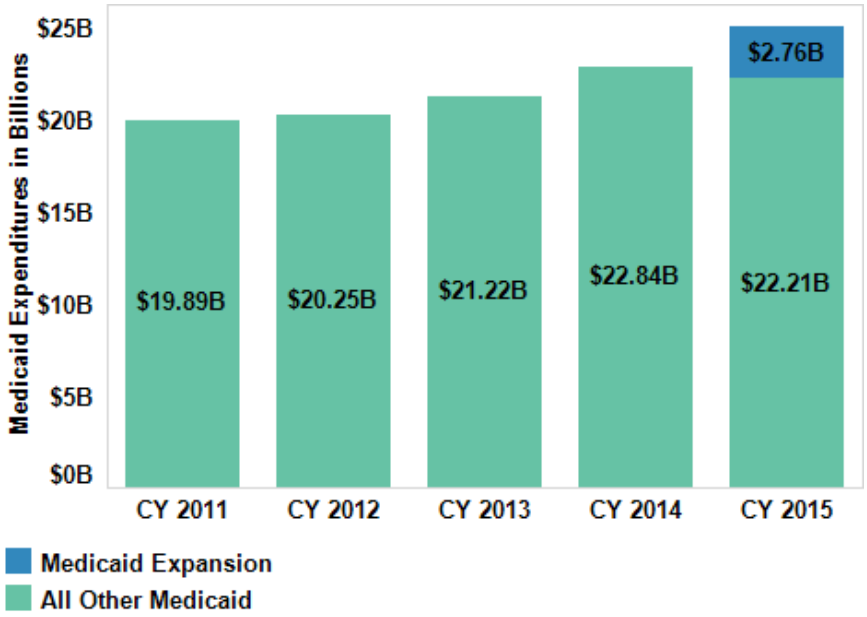
[28] PA DHS. Operations Memorandum #16-03-05, *Medical Assistance Program Changes due to the Introduction of Enhanced Federal Medical Assistance Percentage*, March 10, 2016. Retrieved from *http://services.dpw.state.pa.us/oimpolicymanuals/ma/OPS160305.pdf*.

4.3 Medicaid Expansion Service Expenditures in CY 2015

4.3.1 Total Medicaid Service Expenditures

Expenditures for Medicaid services, as compiled by DHS for CMS 64 federal reporting, have increased annually for the past five calendar years. Service expenditures increased in CY 2015 to $25 billion, representing a 9% increase from CY 2014 as depicted in Figure 14.[29] Whereas Medicaid expansion enrollees accounted for 18% of total Medicaid enrollment in CY 2015, service expenditures for Medicaid expansion accounted for approximately 11% of the total Medicaid service expenditures in CY 2015.

Figure 14. Medicaid Expenditures for Services to Medicaid Expansion and All Other Enrollees from CY 2011 to CY 2015



Administration expenditures are not included the service expenditures compiled for CMS 64 federal reporting.
Figure Source: PA DHS. Prepared for CMS 64 federal reporting and provided by DHS on August 20, 2016 and October 20, 2016 for the purposes of this report.

[29] PA DHS. Retrieved from 'Monthly Eligibility from Data Warehouse - September 2016.xlsx' provided by DHS on October 25, 2016 for the purposes of this report.

4.3.2 Medicaid Expansion Service Expenditures in 2015

Service expenditures for Medicaid expansion enrollees were approximately $2.76 billion in CY 2015. Table 10 summarizes service expenditures incurred by quarter for Medicaid expansion in CY 2015, as prepared by DHS for CMS 64 federal reporting.[30]

Table 10. Service Expenditures for Medicaid Expansion in CY 2015

Actual Expenditures for CY 2015	
Quarter Ending (QE)	**Expenditures**
QE March 2015	$209,058,830
QE June 2015	$520,060,221
QE September 2015	$1,038,580,435
QE December 2015	$991,984,447
Total for CY 2015	**$2,759,683,933**

Table Source: PA DHS. Medicaid Expansion Service Expenditures prepared for CMS 64 by DHS, and provided on August 20, 2016 for the purposes of this report.

[30] PA DHS. Medicaid Expansion service expenditures prepared for CMS 64 by DHS, and provided on August 20, 2016 for the purposes of this report.

5. Additional Economic Impact

5.1 Estimated Economic Impacts of Medicaid Expansion

5.1.1 Background on Modeling Economic Impacts

Highlights

- Results from economic modeling suggest that Medicaid expansion expenditures led to 15,500 jobs, an increase in economic output by $2.2 billion, and an additional $53.4 million in state tax revenue
- DHS paid $1.8 billion to health care providers in CY 2015 for services provided to Medicaid expansion enrollees
- Physicians made up the largest provider type, accounting for 71% of all provider types providing Medicaid services to expansion enrollees between April 2015 and March 2016
- Uncompensated care fell by nearly 9%, from $1.1 billion in CY 2014 to $1 billion in CY 2015 for Pennsylvania's general acute care hospitals

Coverage for the newly eligible Medicaid expansion population generated an infusion of over $1.8 billion in direct health care spending into the Commonwealth in CY 2015. This infusion flowed through Pennsylvania's overall economy, creating jobs, providing tax revenue, and adding economic value to the Commonwealth.

This report used the IMPLAN economic modeling software to estimate that economic impact. The software uses an input-output methodology that is commonly used for modeling economic impacts. This approach has been a staple in many tax increments financing (TIF) and tax deferred annuity (TDA) project reports over the past decade, as it quantifies the impact of cash flows in one sector on other sectors in the economy. In the public sector, IMPLAN has generally been used to inform policy makers on the overall impact of program decisions. Within the Commonwealth, its modeling capabilities have been used on a number of occasions, including an Office of Community and Economic Development return on investment (ROI) report in 2014.[31]

For this review of the impact of Medicaid Expansion on the Commonwealth in CY 2015, the IMPLAN tool modeled the total economic effect on a variety of indicators across the Commonwealth, such as outputs, total value added (Gross Regional Product), full-time equivalent (FTE) employment counts, and state taxes.[32]

Payments made to providers in CY 2015 for newly eligible Medicaid Expansion enrollees (i.e., medical assistance categories MG 91 and PCO 91) were inputted into the tool after the application of a discount factor to estimate the percentage of those payments that could be attributed to former enrollees in the Commonwealth's General

[31] PA Office of Community & Economic Development. *Return on Investment and Budget.* Retrieved from pa.gov: *http://dced.pa.gov/business-assistance/international/return-on-investment-and-budget/#.WBgQtxozX_c.*

[32] IMPLAN models economic outcomes given purchasing and transaction data. In no way are these results actual or definite.

Assistance (GA) Medical Assistance program who migrated into Medicaid expansion. The discount factor is applied based on the assumption that if Medicaid expansion had not taken place, the Commonwealth would have continued coverage for the GA Medical Assistance program at the same levels as the prior year. The discount factor reduced provider payments for newly eligible Medicaid expansion enrollees in CY 2015 by the amount of provider payments for GA Medical Assistance enrollees in CY 2014. [33]

5.1.2 Impact of Expansion on Outputs by Sector

Output, which refers to the value of intermediate and final goods produced in a time period, is one metric the IMPLAN model produces to size and gauge economic impact. This approach to modeling economic impact estimates that the $1.8 billion spent on health services for the newly eligible Medicaid expansion population led to a total of $2.2 billion in CY 2015 output along Pennsylvania's supply chain across all sectors. Table 14 summarizes the total effect[34] that expenditures in CY 2015 for the newly eligible Medicaid expansion population produced for the top ten sectors.[35] See Table 31 in the Appendix for a full breakdown of all sectors.

Table 11. Projected Impact of Medicaid Expansion on Outputs for the Top 10 Industry Sectors in CY 2015

Top 10 Sectors	Total Effects on Outputs
Health & Social Services	$1,013,751,946
Retail Trade	$307,434,555
Real Estate & Rental	$198,354,368
Finance & Insurance	$146,793,600
Professional, Scientific, & Technical Services	$79,910,886
Information	$63,581,267
Manufacturing	$60,124,985
Wholesale Trade	$54,041,184
Administrative & Waste Services	$51,494,433
Other Services	$41,423,958
Total for Top 10 Sectors	**$2,016,911,182**

Table Source: IMPLAN economic impact analysis. PA DHS provided input data for IMPLAN modeling, containing Medicaid expenditures for health care services in CY 2015 attributable to newly eligible Medicaid expansion enrollees. Provider payments amounts were adjusted to reflect the costs associated with the former enrollees in the GA Medical Assistance program in CY 2014 who migrated into Medicaid expansion in 2015.

[33] Based on the provider payments for GA Medical Assistance enrollees in CY 2014 and for newly eligible Medicaid expansion enrollees in CY 2015, the discount percentage of 56.93% was applied.

[34] Total Effect is the sum of three different types of impacts: direct effects, indirect effects, and induced effects. Direct effects are purchases made by health care consumers. Indirect effects are purchases made by suppliers to support manufacturing of these health care products. Induced effects are purchases made by individuals employed by health care industry with earnings.

[35] PA DHS provided input data containing Medicaid expenditures for health care services in CY 2015 attributable to Pennsylvania's Medicaid expansion for the purpose of IMPLAN modeling.

5.1.3 Impact of Expansion on Employment and Compensation by Sector

The IMPLAN model also indicates that expenditures in CY 2015 for the newly eligible Medicaid expansion population had an impact on employment and compensation. According to the model, the influx of spending on services for the newly eligible Medicaid expansion enrollees resulted in the FTE employment of approximately 15,500 individuals. Of that, roughly half of the FTE employees were created in the health and social services sector. Furthermore, IMPLAN projections suggest that the retail trade sector (which includes pharmacy, durable medical equipment, and medical supplies) experienced the second largest impact adding 3,339 FTE employees. These two sectors combined account for seven out of every ten projected FTE employment opportunities resulting from Medicaid expansion expenditures.

The table below provides a breakdown of the top 10 sectors impacted by newly eligible Medicaid expansion expenditures in terms of projected increased FTE employment counts, and represents the vast majority (94%) of total projected increased FTE employment.[36] For a full breakdown for all sectors, see Table 32 in the Appendix.

Table 12. Projected Impact of Medicaid Expansion on FTE Employment Counts for the Top 10 Industry Sectors in CY 2015

Top 10 Sectors	Total Effect on Full-Time Equivalent (FTE) Employment
Health & Social Services	7,434
Retail Trade	3,339
Administrative & Waste Services	692
Finance & Insurance	641
Accommodation & Food Services	568
Professional, Scientific, & Technical Services	550
Other Services	465
Real Estate & Rental	439
Transportation & Warehousing	271
Wholesale Trade	208
Total for Top 10 Sectors	**14,608**

Table Source: IMPLAN economic impact analysis. PA DHS provided input data for IMPLAN modeling, containing Medicaid expenditures for health care services in CY 2015 attributable to newly eligible Medicaid expansion enrollees. Provider payments amounts were adjusted to reflect the costs associated with the former enrollees in the GA Medical Assistance program in CY 2014 who migrated into Medicaid expansion in 2015.

Using the FTE modeling across multiple sectors, IMPLAN also extrapolates labor income paid to this workforce.[37] The modeling suggests that newly eligible Medicaid expansion expenditures in CY 2015 was responsible for creating more than $900 million in income. Of which, more than $700 million was projected for labor in the health and social services and retail trade sectors. The following table breaks down the top 10

[36] Full-time equivalent (FTE) employment convert full- and part-time employee counts into full-time equivalent employee counts.

[37] Labor Income is the sum of employee compensation and proprietor income.

sectors for projected labor income and represents the more than 90% of the total projected labor income for all sectors. For a full breakdown for all sectors, see Table 33 in the Appendix.

Table 13. Projected Impact of Medicaid Expansion on Labor Income for the Top 10 Industry Sectors in CY 2015

Top 10 Sectors	Total Effect on Labor Income
Health & Social Services	$550,273,340
Retail Trade	$159,102,039
Finance & Insurance	$49,935,981
Professional, Scientific, & Technical Services	$46,036,646
Administrative & Waste Services	$28,651,360
Other Services	$22,498,662
Information	$19,951,314
Wholesale Trade	$19,647,485
Accommodation & Food Services	$15,827,340
Management of Companies	$15,785,821
Total for Top 10 Sectors	**$927,709,988**

Table Source: IMPLAN economic impact analysis. PA DHS provided input data for IMPLAN modeling, containing Medicaid expenditures for health care services in CY 2015 attributable to newly eligible Medicaid expansion enrollees. Provider payments amounts were adjusted to reflect the costs associated with the former enrollees in the GA Medical Assistance program in CY 2014 who migrated into Medicaid expansion in 2015.

5.1.4 Impact of Expansion on the Business Taxes and Commonwealth's Tax Revenue

Spending and economic activity related to expenditures on the newly eligible Medicaid expansion population also led to additional business taxes and state tax revenues. The modeling suggests that expenditures for newly eligible Medicaid expansion enrollees in CY 2015 was responsible for $68.6 million net indirect business taxes. The following table breaks down the top 10 sectors for projected indirect business taxes, which consists of excise taxes, property taxes, fees, licenses, and sales taxes paid by businesses. These taxes occur during the normal operation of businesses, but do not include taxes on profit or income. Of the total projected indirect business taxes, over $25.7 million was from the health and social services and retail trade sectors. For a full breakdown for all sectors, see Table 34 in the Appendix.

Table 14. Projected Impact of Medicaid Expansion on Indirect Business Taxes for the Top 10 Industry Sectors in CY 2015

Top 10 Sectors	Indirect Business Taxes
Retail Trade	$21,267,888
Real Estate & Rental	$16,711,063
Wholesale Trade	$7,206,807
Health & Social Services	$4,467,937
Finance & Insurance	$4,279,055
Utilities	$2,800,941

Top 10 Sectors	Indirect Business Taxes
Information	$2,212,019
Accommodation & Food Services	$2,120,432
Other Services	$2,086,547
Professional, Scientific, & Technical Services	$1,807,296
Total for Top 10 Sectors	**$64,959,986**

Table Source: IMPLAN economic impact analysis. PA DHS provided input data for IMPLAN modeling, containing Medicaid expenditures for health care services in CY 2015 attributable to newly eligible Medicaid expansion enrollees. Provider payments amounts were adjusted to reflect the costs associated with the former enrollees in the GA Medical Assistance program in CY 2014 who migrated into Medicaid expansion in 2015.

As shown in Table 15, hospitals and retail health providers (which includes pharmacy, durable medical equipment, and medical supplies) combined contributed nearly 69% of projected state taxes, or $37.0 million in CY 2015.[38] The IMPLAN model includes the following types of state taxes: corporate profits tax, income tax, motor vehicle license tax, natural resource/severance tax, property tax, sales tax, and social insurance tax. This state tax represents a broader set of taxes than those recorded within indirect business taxes; however, indirect business taxes include both a state and local component, whereas the former does not, and only includes state tax. The table below breaks down estimated state tax revenue effect specifically within the health and social services sector.

Table 15. Projected Impact of Medicaid Expansion on State Taxes in CY 2015 on Industries in the Health and Social Services Sector

Industries in Health & Social Services Sector	State Taxes	Percent of the Total State Taxes
Retail - Health and Personal Care	$19,339,957	36%
Hospitals	$17,715,384	33%
Offices of Physicians	$6,270,775	12%
Outpatient Care Centers	$5,608,509	11%
Individual and Family Services	$1,351,310	3%
Residential Mental Retardation, Mental Health, Substance Abuse and Other Facilities	$1,117,813	2%
Nursing and Community Care Facilities	$512,982	1%
Offices of Other Health Practitioners	$472,228	1%
Other Ambulatory Health Care Services	$408,457	1%
Medical and Diagnostic Laboratories	$344,174	0%
Home Health Care Services	$212,442	0%
Offices of Dentists	$15,046	0%
Total	**$53,369,077**	**100%**

Percentage totals are approximate due to rounding.

Table Source: IMPLAN economic impact analysis. PA DHS provided input data for IMPLAN modeling, containing Medicaid expenditures for health care services in CY 2015 attributable to newly eligible Medicaid expansion enrollees. Provider payments amounts were adjusted to reflect the costs associated with the former enrollees in the GA Medical Assistance program in CY 2014 who migrated into Medicaid expansion in 2015.

[38] Supplemental analysis was performed to separate state and local taxes as reported by IMPLAN into a state taxes component. To separate state and local taxes as reported by IMPLAN into a state tax proportion only, data from the U.S. Census Bureau for Pennsylvania was applied, and retrieved from http://factfinder2.census.gov/bkmk/table/1.0/en/SLF/2013/SLF003.

5.2 Impact on Providers

5.2.1 Health Care Service Payments to Providers for Medicaid Expansion

Reimbursements for health care services provided to Medicaid expansion enrollees totaled more than $1.8 billion in CY 2015. The following table shows payments by sector made to health care service providers in CY 2015 for newly eligible Medicaid expansion enrollees (i.e., medical assistance categories MG 91 and PCO 91). Total payments included $277 million in FFS payments and $1.5 billion through the managed care delivery systems (i.e., PCO and HealthChoices). Approximately $4 out of every $10 paid to providers was for hospital-related services. Health and personal care retail providers (which include pharmacies, durable medical equipment, and medical supplies) represented nearly a quarter of all payments made. Those two categories of service combine to make up the majority (65%) of all payments made to providers for Medicaid expansion health care services.[39]

Table 16. Provider Payments by Sector for Health Care Services for Newly Eligible Medicaid Expansion Enrollees in CY 2015

Sector	Percent of Provider Payment from FFS	Percent of Provider Payment from Managed Care	Total Provider Payments for Newly Eligible Medicaid Expansion Enrollees	Percent of Total Payments
Hospitals	31%	69%	$768,089,939	43%
Retail - Health and Personal Care	3%	97%	$395,550,439	22%
Outpatient Care Centers	1%	99%	$247,730,435	14%
Offices of Physicians	8%	92%	$216,382,362	12%
Individual and Family Services	0%	100%	$47,281,720	3%
Residential Mental Retardation, Mental Health, Substance Abuse and Other Facilities	0%	100%	$39,320,015	2%
Offices of Other Health Practitioners	2%	98%	$17,339,163	1%
Other Ambulatory Health Care Services	14%	86%	$16,085,018	1%
Medical and Diagnostic Laboratories	7%	93%	$13,013,502	1%
Nursing and Community Care Facilities	9%	91%	$8,220,432	0%
Home Health Care Services	36%	64%	$5,575,981	0%
Offices of Dentists	0%	100%	$557,368	0%
Total Payments	**100%**	**100%**	**$1,775,146,374**	**100%**

[39] These funds solely cover the cost of providing health care services and exclude general and administrative costs. Payments of $23.5 million for Capitation, Physical Health Managed Care Organizations (MCOs) and unknown provider types were excluded.

PA DHS. Retrieved from *Medicaid Payments (FFS and MCO) to Providers by Provider Type and Specialty for Medicaid Expansion Enrollees* provided by DHS on December 27, 2016 for the purposes of this report, and aligned to sectors as an input for IMPLAN modeling.

These payment funds represent the cost of providing health care services to medical assistance categories MG 91 and PCO 91, and exclude general and administrative costs. Payments of $23.5 million for Capitation, Physical Health Managed Care Organizations (MCOs) are excluded.

Table Source: Retrieved from Medicaid Payments (FFS and MCO) to Providers by Provider Type and Specialty for Medicaid Expansion Enrollees *provided by DHS on December 27, 2016 for the purposes of this report, and aligned to sectors as an input for IMPLAN modeling.*

Based on payments in CY 2015, the top five types of providers, as seen below, received 92% of payments made for health care services for newly eligible Medicaid expansion enrollees.

Table 17. Payments to the Top Five Provider Types for Health Care Services for Medicaid Expansion Enrollees in CY 2015

Top 5 Provider Types	Payments for Newly Eligible Medicaid Expansion Enrollees	Percent of Total Payments
Inpatient Facility	$767,581,966	43%
Pharmacy	$381,017,990	21%
Physician	$215,104,582	12%
Mental Health / Substance Abuse	$181,191,004	10%
Clinic	$87,305,302	5%
All Other Provider Types	$142,945,530	8%
Total Payments	**$1,775,146,374**	**100%**

These payment funds represent the cost of providing health care services to medical assistance categories MG 91 and PCO 91, and exclude general and administrative costs. Payments of $23.5 million for Capitation, Physical Health Managed Care Organizations (MCOs) are excluded.

Table Source: Retrieved from Medicaid Payments (FFS and MCO) to Providers by Provider Type and Specialty for Medicaid Expansion Enrollees *provided by DHS on December 27, 2016 for the purposes of this report.*

5.2.2 Providers Serving Medicaid Expansion

The Commonwealth has 47 unique provider types enrolled in its network of Medicaid providers.[40] Over 66,000 providers were paid for Medicaid services between April 1, 2015 and March 31, 2016. Of those 66,000 providers, 67% (44,093 providers) were paid for services provided to newly eligible Medicaid expansion enrollees.[41] The table below tracks the top 10 types of providers/practitioners that served newly eligible Medicaid expansion enrollees. Physicians made up the majority (71%) of all Medicaid

[40] As required by the ACA, DHS has a process to revalidate enrolled providers, which must be completed procedurally in order for DHS to make FFS reimbursements to each provider. By the end of December 2015, DHS had over 153,000 providers enrolled in its fee-for-service (FFS) delivery system and validated in its network.

PA DHS. Validated provider enrollment provided by DHS on August 29, 2016. Throughout Calendar Year 2015, DHS revalidated nearly 60,000 additional Medicaid providers.

[41] PA DHS. Calculated from enrollment and utilization data provided by DHS on January 3, 2017 for the purposes of this report.

providers serving the newly eligible expansion population group during the studied period.

Table 18. Top 10 Provider Types that Provided Health Care Services to Medicaid Expansion Enrollees during April 2015 to March 2016

Top 10 Provider Types	Count of Providers that Served Medicaid Expansion Enrollees	Percent of Total Providers that Served Medicaid Expansion Enrollees
Physician	31,365	71%
Certified Registered Nurse Practitioner	2,074	4%
Mental Health/Substance Use Disorder	1,457	3%
Therapist	1,334	3%
Dentist	1,086	2%
Certified Registered Nurse Anesthetist	836	1%
Optometrist	801	1%
Clinic	703	1%
Inpatient Facility	677	1%
Podiatrist	465	1%

Performing providers received payment for health care services between April 1, 2015 and March 31, 2016 to medical assistance categories MG 91 and PCO 91.

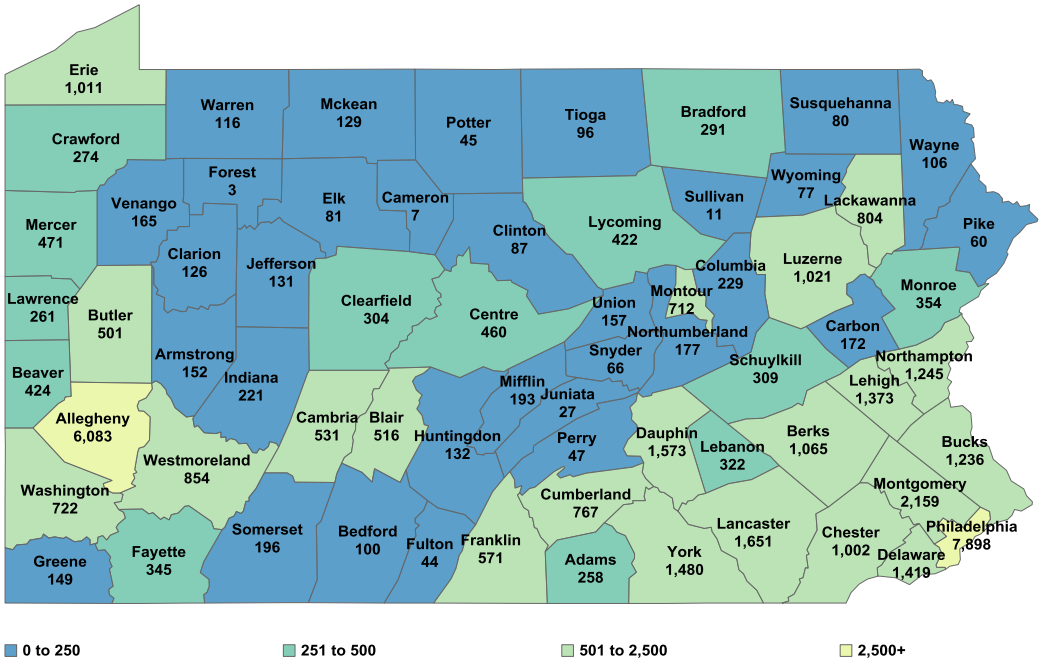
Percentage totals are approximate due to rounding.

Table Source PA DHS. Calculated from enrollment and utilization data provided by DHS on December 27, 2016 and January 11, 2017 for the purposes of this report.

The following figure maps the total number of providers that provided services to newly eligible Medicaid expansion enrollees between April 1, 2015 and March 31, 2016. Philadelphia and Allegheny Counties, which have the most Medicaid expansion enrollees, also have the greatest concentration of health care providers serving expansion enrollees. Combined, these two counties had 13,981 providers and represented 32% of all providers serving expansion enrollees. See Section 8.8 in the Appendix for county maps of select provider types serving newly eligible Medicaid expansion enrollees between April 1, 2015 and March 31, 2016.[42]

[42] PA DHS. *Enrolled Provider Counts by Category of Service and County in 2015*. Provided by DHS on August 25, 2016 for the purposes of this report.

Figure 15. Medicaid Enrolled Providers that Provided Paid Medicaid Services to Medicaid Expansion Enrollees between April 1, 2015 and March 31, 2016



Performing providers received payment for health care services between April 1, 2015 and March 31, 2016 to medical assistance categories MG 91 and PCO 91.

Figure Source: PA DHS. Calculated from enrollment and utilization data provided by DHS on January 3, 2017 for the purposes of this report.

5.3 Reductions in Hospital Uncompensated Care

Uncompensated care is the total amount of health care services provided to patients who are either unwilling or unable to pay, capturing both uncollectible debt and charity care incurred by health care providers. According to data compiled by the Pennsylvania Cost Containment Council (PHC4), the value of uncompensated care provided by hospitals in the Commonwealth decreased in 2015. Prior to 2015, there was a steady increase in the dollar value of uncompensated care since 2001 for general acute care hospitals, which rose from $461 million in providers' fiscal year 2001 to $1.07 billion in 2014.[43]

[43] Pennsylvania Health Care Cost Containment Council (PHC4) is an independent state agency that gathers, analyzes, and reports information about the cost and quality of health care in Pennsylvania. Note that PHC4 publishes additional volumes for ambulatory surgery centers and non-general acute care hospitals. Financial Analysis Reports and News Release retrieved from phc4.org: http://www.phc4.org/reports/fin/.

Figure 16. Statewide Uncompensated Care for General Acute Care Hospitals from 2001 to 2015

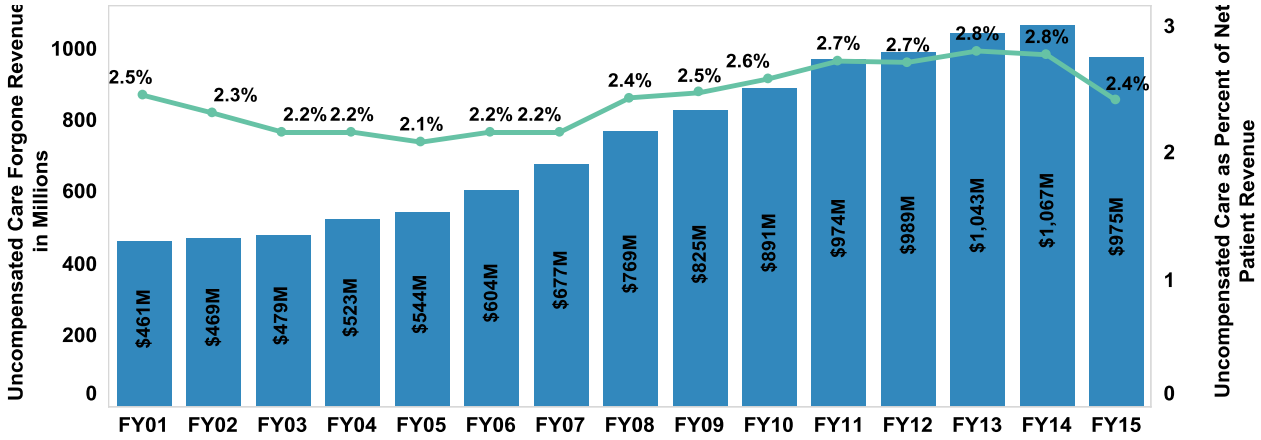


Figure Source: PHC4 Financial Analysis 2015. An Annual Report on the Financial Health of Pennsylvania Hospitals, Volume 1: General Acute Care Hospitals. *Retrieved from phc4.org: http://www.phc4.org/reports/fin/15/.*

Since 2001, the total dollar amount of uncompensated care increased annually until 2015. In 2015, when Medicaid expansion occurred, the dollar amount of uncompensated care provided by general acute care hospitals decreased by $92 million or 8.6%, from $1.07 billion in providers' fiscal year 2014 to $975 million in FY 2015. As a percent of net patient revenue, uncompensated care decreased from 2.8% to 2.4% from 2014 to 2015, as seen in the following figure. Uncompensated care as a percentage of net patient revenue for psychiatric services also fell from 1.6% to 1.3%. Similarly, uncompensated care for specialty services fell marginally from 1.9% to 1.8%. Collectively, the forgone revenue among non-general acute care hospitals declined during the provider's FY 2015 by $19.9 million. [44]

It is important to note that fluctuations in these rates do not necessarily point to changes in uncompensated care; they could have been impacted by changes in net patient revenue. Other provisions of the ACA beside Medicaid expansion could also have impacted these results such as the foster care, individual mandate and employer mandate provisions.

[44] The hospitals data included herein is based on facility fiscal year 2015 (FY 2015). The fiscal year for the majority of hospitals is on a calendar year basis ending on December 31. For those hospitals that do not utilize a calendar year basis, the fiscal year typically ends on June 30 annually.

PHC4 Financial Analysis Annual Reports, 2015, on the Financial Health of Pennsylvania Hospitals. Retrieved from phc4.org: http://www.phc4.org/reports/fin/15/.

Figure 17. Statewide Hospital Uncompensated Care as Percentage of Net Patient Revenue by Provider Fiscal Year

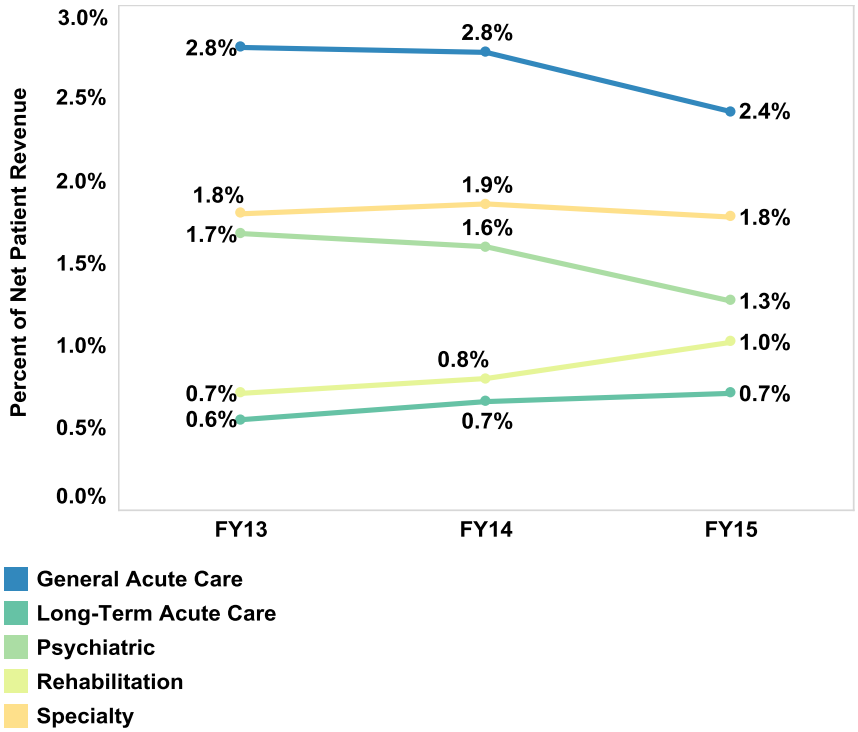


Figure Source: PHC4 Financial Analysis Annual Reports, 2013 to 2015, on the Financial Health of Pennsylvania Hospitals. Retrieved from phc4.org: http://www.phc4.org/reports/fin/15/.

Individual general acute care hospitals reported varying changes to net patient revenue and uncompensated care costs in their fiscal year 2015. The hospitals with increases in net patient revenue over $100,000 included Allegheny General ($370,238); Magee-Women's, University of Pittsburgh Medical Center ($326, 685); West Penn ($212,100); Lehigh Valley Allentown ($127,299); Jefferson ($111,587); Hospital of the University of Pennsylvania ($108,762); Milton S. Hershey ($103,570); and Forbes ($101,930). Of the 170 hospitals for which PHC4 collected data, 132 had increased net patient revenue and 115 showed a decrease in uncompensated care. Hospitals showing decreases over two percentage points included Shriners Children, Philadelphia (-2.34); Punxsutawney Area (-2.23%); Roxborough Memorial (-2.23%); Conemaugh Meyersdale (-2.20%); and Bucktail (-2.17%). See Section 8.9 in the Appendix for uncompensated care by general acute care hospital.[45]

[45] PHC4 Financial Analysis 2015. *An Annual Report on the Financial Health of Pennsylvania Hospitals, Volume 1: General Acute Care Hospitals.* Retrieved from phc4.org: http://www.phc4.org/reports/fin/15/.

pennsylvania
DEPARTMENT OF HUMAN SERVICES

6. Early Assessment of the Medicaid Expansion Population

Medicaid expansion extended a broad range of health services to a group of low-income individuals who for the most part did not have prior access to comprehensive health care insurance coverage. This section of the report first examines the demographic profile of the newly eligible Medicaid expansion enrollees based on the person's eligibility in medical assistance categories MG 91 or PCO 91 and then analyzes key health status and utilization statistics for this new population group.

Highlights

Newly eligible Medicaid expansion enrollees from April 1, 2015 through March 31, 2016 had the following characteristics:

- 44% were between the ages of 19 and 32 years old
- 55% were female
- 84% were not enrolled in any other form of third-party health care coverage
- 45% received a preventative service(s)
- 27% had at least one Emergency Room visit
- 5% were admitted into the hospital for inpatient services
- 146,694 individuals, or 17% of the expansion group, had a cardiovascular condition
- 44,887 individuals, or 5% of the expansion group, had a diagnosis of Diabetes Type 2
- 97,185 individuals, or 11.5% of the expansion group, had a Substance Use Disorder

The data for this section draws from health care claims and encounters for dates of services from April 1, 2015, through March 31, 2016, along with the corresponding enrollment of newly eligible individuals in Medicaid expansion on the date of service delivery. This period was selected instead of CY 2015 because of concerns about the consistency of the data recorded during the Medicaid expansion program transition in the first quarter of CY 2015. During this 12-month period, an unduplicated count of 855,317 unique individuals were in the Medicaid expansion population group.

Overall, the profile of the Medicaid expansion population was analyzed by comparing their characteristics and experience with a comparison group of traditional Medicaid eligible enrollees, ages 19 to 64 years old, during the same period.[46]

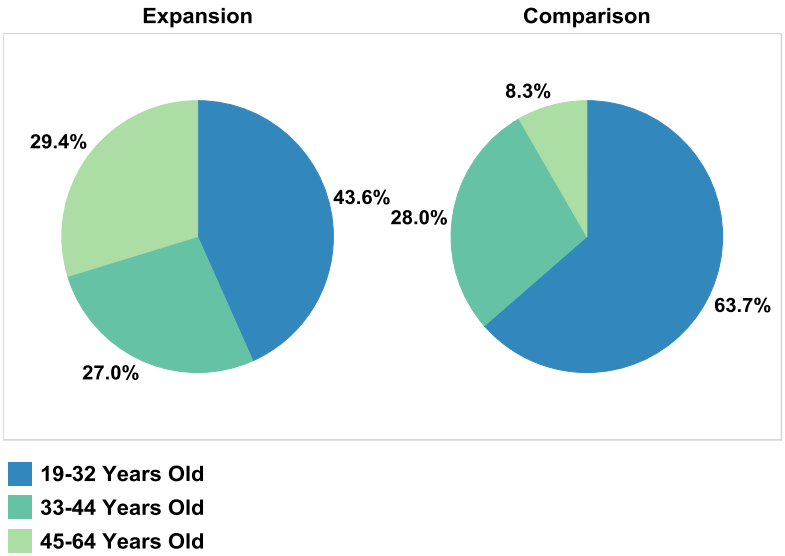
[46] Comparison group are enrollees within the following categories of assistance (COA): TANF (excluding TANF diversion) [C (excluding C47,C48, C49)]; TANF/CU (excluding TANF diversion) [U (excluding U47, U48, U49)]; NMP TANF [PC]; NMP TANF LTC - State Adoption Asst Long Term Care [PCN 34]; MNO TANF [TC]; MNO TANF/CU[TU]; General Asst. RFP/RCA (Refugee Cash Assist) and Repatriated National [D]; NMP GA Chronically Needy [PD]; MNO GA Chronically Needy [TD]; Family Planning Services Program / Select Plan for Women [PSF]; MAGI or Hospital Based Presumptive Eligibility [MG00, MG17, MG18, MG19, MG27, MG71]; or NMP SMA Presumptive Eligibility [PS17].

6.1 Demographics

6.1.1 Age, Gender, and Race

Seventy-one percent (71%) of newly eligible Medicaid expansion enrollees during the 12-month time period were between 19 and 44 years old. The newly eligible Medicaid expansion population was made up of more females than males (55% vs. 45%), and was predominantly white (61%).

Figure 18. Individuals Enrolled in Medicaid Expansion between April 1, 2015 and March 31, 2016, by Age as a Proportion of Total Population for each Category



The category of eligibility for Medicaid expansion enrollees over 64 years old as of January 3, 2017 are not depicted in this figure.

Figure Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

As the following figure shows**,** 55% of the newly eligible Medicaid expansion population was female.[47] In contrast, 77% of the comparison group was female. The larger female population in the comparison group is a reflection of the eligibility criteria used for the traditional Medicaid population (e.g., children and families, pregnant women).

Figure 19. Individuals Enrolled in Medicaid Expansion between April 1, 2015 and March 31, 2016 by Gender as a Proportion of Total Population for each Category

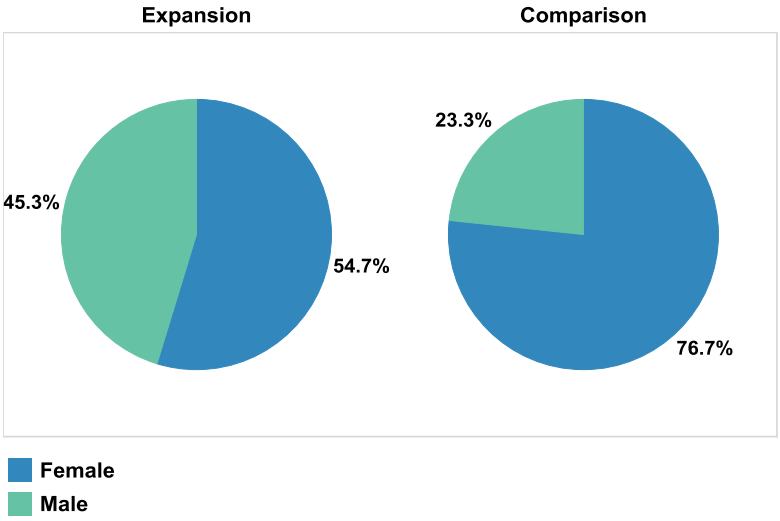


Figure Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

[47] *Ibid.*

The majority of the newly eligible Medicaid expansion population was white (61%), as shown in the following figure, with African Americans making up 24% of the population. Similarly, the majority of the comparison group was white (56%) with African Americans making up 27% of the group.

Figure 20. Individuals Enrolled in Medicaid Expansion between April 1, 2015 and March 31, 2016 by Race as a Proportion of Total Population for each Category

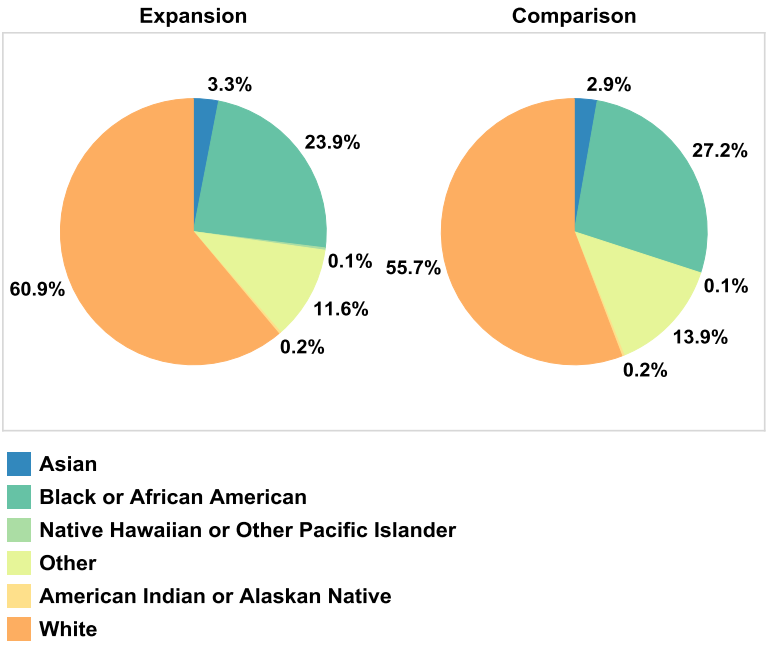


Figure Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

6.1.2 Work, Housing, Parental, Marital, and Income Status

Forty-three percent (43%) of newly eligible Medicaid expansion enrollees were employed, 24% were working part-time and 19% were working full-time. Fifty-seven percent (57%) had no work history or were unemployed. Of the 55% who reported their housing status, a small percentage (3%) indicated that they were homeless. Of the 39% of the newly eligible Medicaid expansion enrollees who self-reported parental or guardian status, 95% identified themselves as not being parents or guardians. Of the 86% who self-reported marital status, 65% identified themselves as never having been married. Of the 46% who reported their income status, 42% had incomes between 0% and 50% of the FPL.[48]

[48] *Ibid.*

6.1.3 Third Party Liability (TPL) Resource

Almost 16% of the newly eligible Medicaid expansion enrollees, as compared to 12% of the comparison population, were also enrolled in another type of health care insurance coverage through an employer, spousal coverage, individual commercial coverage, Medicare or other form of insurance, known as having a third party liability (TPL) resource.

Figure 21. Individuals Enrolled in Medicaid Expansion between April 1, 2015 and March 31, 2016 with TPL Resources as a Proportion of Total Populations for each Category

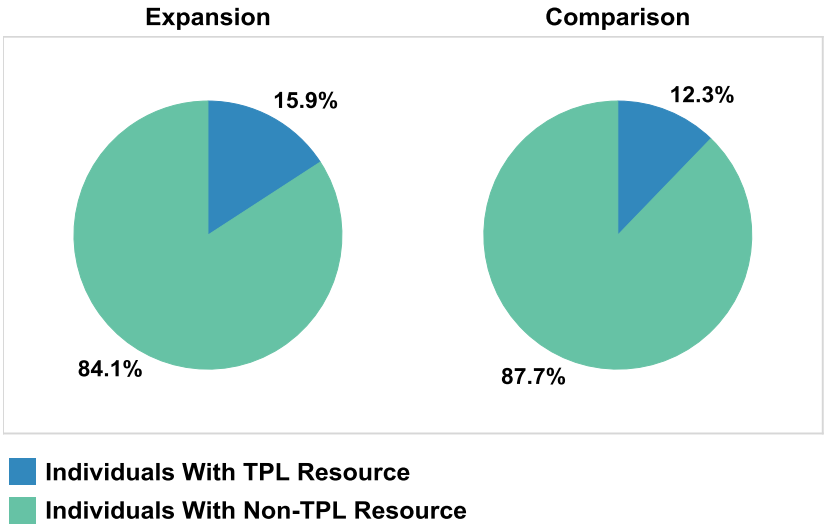


Figure Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

6.2 Health Care Utilization and Health Status

6.2.1 Most Common Provider Types

The following table depicts the 10 most frequented provider types by the Medicaid expansion population between April 1, 2015, and March 31, 2016.[49] The majority of individuals in the newly eligible Medicaid expansion population group used physician services (89%) and inpatient facility services (63%) during the studied time. The usage of providers by the newly eligible Medicaid expansion population was similar with the comparison group. More information on performing providers serving the Medicaid expansion population group during the studied period is available in Section 5.2.2 and Section 8.8 of this report.

[49] *Ibid.*

Table 19. Top 10 Provider Types Providing Medicaid Paid Services between April 1, 2015 and March 31, 2016 by Medicaid Expansion and Comparison Population Groups

Top 10 Provider Types	Percent of Individuals With Use of Provider	
	Medicaid Expansion Group	Comparison Group
Physician	89%	92%
Inpatient Facility	63%	69%
Laboratory	29%	36%
Clinic	20%	22%
Certified Registered Nurse Practitioner	15%	19%
Dentist	10%	12%
Mental Health/Substance Use Disorder	10%	7%
Transportation	9%	10%
Optometrist	9%	10%
DME/Medical Supplies	8%	12%

Physicians include the following specialties: allergy & immunology, anesthesiology, autism certified psychiatrist, dermatology, emergency medicine, family practice, general practitioner, hearing aid dispenser, internal medicine, neurology, obstetrics and gynecology, ophthalmologist, orthopedic surgery, otolaryngology pathology, pediatrics, physical medicine and rehabilitation, plastic surgery, preschool early intervention service, preventive medicine, program exception, psychiatry, radiation therapist, radiology, surgery, tobacco cessation, and urologist.
Inpatient facilities include the following: acute care hospital, drug and alcohol rehab unit, emergency room arrangement 2, extended acute psych inpatient unit, hospital based medical clinic, inpatient drug and alcohol , hospital, inpatient medical rehab hospital, inpatient medical rehab unit, private psychiatric hospital, private psychiatric unit, public psychiatric hospital, residential treatment facility (JCAHO certified), and short procedure unit.[50]
Table Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

6.2.2 Most Common Chronic Conditions among the Expansion Population

To determine the most common chronic conditions for the newly eligible Medicaid expansion enrollees and the comparison group, utilization data was analyzed using the Chronic Illness and Disability Payment System (CDPS). DHS uses CDPS to risk adjust the capitation rates paid to the HealthChoices MCOs. The following figure shows the top 10 most common chronic conditions and HIV/AIDS diagnoses between April 1, 2015 and March 31, 2016, and the percent of the population group with the condition. As shown in the following figure, the newly eligible Medicaid expansion population had a higher prevalence rate for most of the following conditions with the exception of mental health conditions. Most notable among the newly eligible Medicaid expansion enrollees was the higher prevalence of cardiovascular (17.3%), skeletal (12.3%), substance use disorder (11.5%), mental health (18.8%), and gastrointestinal (11.2%) conditions. HIV/AIDS diagnosis rates were similar between both groups.

[50] More information on provider specialties within each provider type can be found at http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

Figure 22. Percent of Individuals Diagnosed with the 10 Most Common Chronic Conditions between April 1, 2015 and March 31, 2016 by Medicaid Expansion and Comparison Population Groups

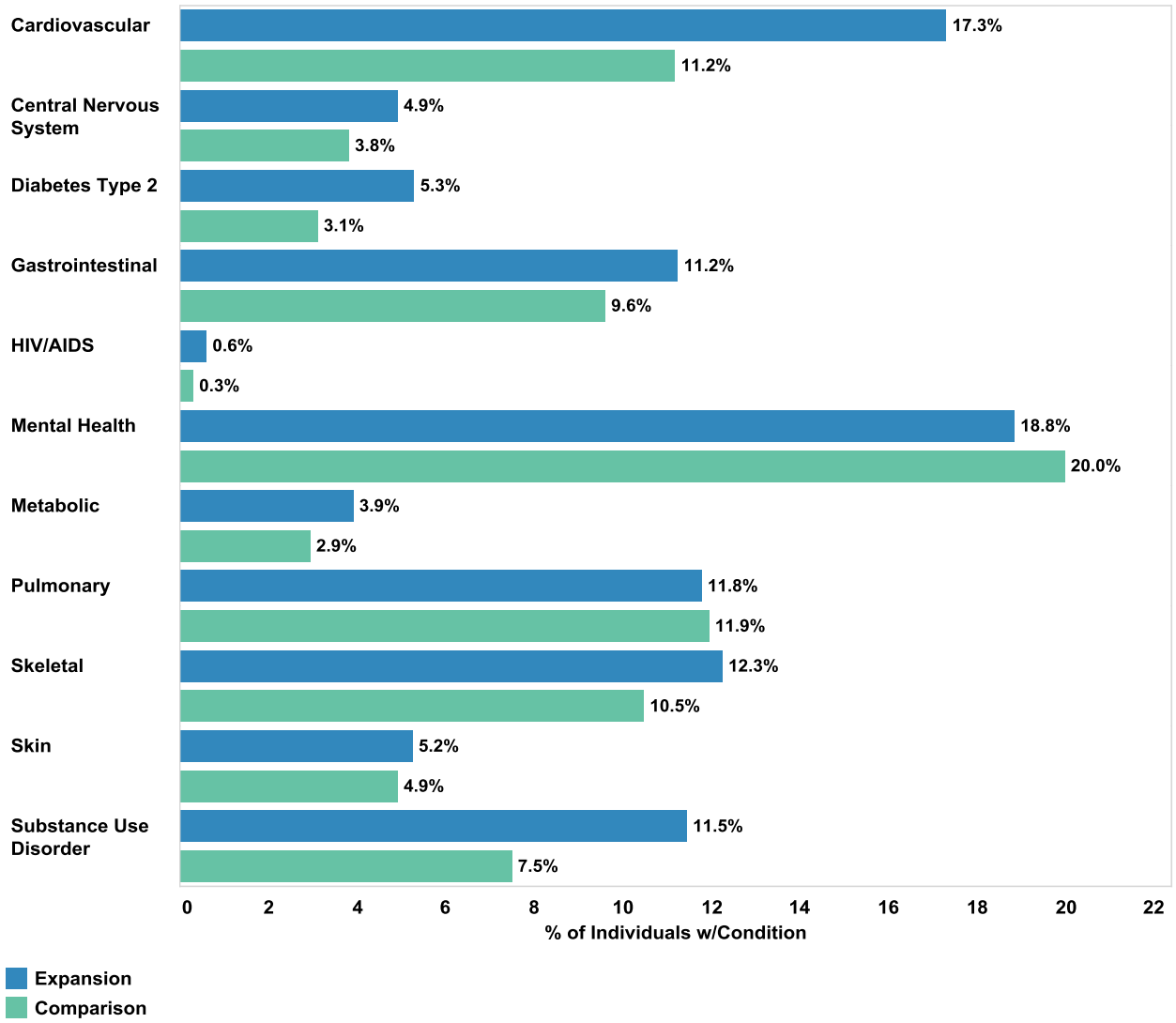


Figure Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

Similar to the figure above, Table 20 shows the count of individuals with the top 10 most common chronic conditions and HIV/AIDS diagnoses between April 1, 2015 and March 31, 2016. For example, 97,185 newly eligible expansion enrollees had a substance use disorder, which represents 11.5% of the expansion population group during the studied time period. Mental health diagnoses were slightly lower in the newly eligible expansion population (18.8%) than in the comparison population (20.0%) as a percentage of the population. However, when comparing the total number of individuals, a higher number

of individuals in the expansion population had a mental health condition (159,923) than in the comparison population (66,929).

Table 20. Count of Individuals Diagnosed with the 10 Most Common Chronic Conditions between April 1, 2015 and March 31, 2016 by Medicaid Expansion and Comparison Population Groups

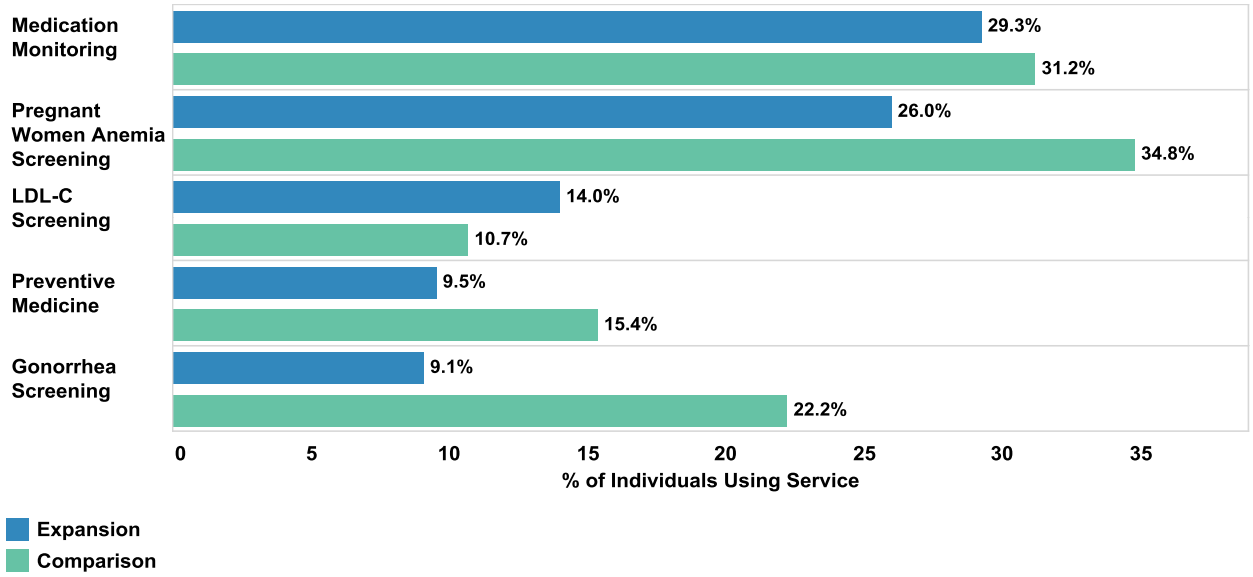
Most Common Chronic Conditions and HIV/AIDS Diagnoses	Count of Individuals With Condition / Diagnosis	
	Medicaid Expansion Group	Comparison Group
Cardiovascular	146,694	37,421
Central Nervous System	41,743	12,739
Diabetes Type 2	44,887	10,397
Gastrointestinal	95,270	32,222
HIV/AIDS	5,141	1,036
Mental Health	159,923	66,929
Metabolic	33,340	9,866
Pulmonary	99,847	40,009
Skeletal	103,948	35,097
Skin	44,525	16,523
Substance Use Disorder	97,185	25,146

Table Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

6.2.3 Most Common Preventative Care Services

Approximately 45% of newly eligible Medicaid expansion enrollees received at least one preventative service in the 12-month period from April 1, 2015, to March 31, 2016. The five most commonly utilized preventative care services by the Medicaid expansion enrollees were Medication Monitoring, Pregnant Women Anemia Screening, Low-Density Lipoprotein Cholesterol (LDL-C) Screening, Preventative Medicine, and Gonorrhea Screening.[51] The following figure shows the percent of individuals enrolled in the Medicaid expansion and the comparison group that utilized these services during the reporting period.[52]

Figure 23. Five Most Commonly Used Preventative Services between April 1, 2015 and March 31, 2016, by Medicaid Expansion and Comparison Population Groups



Non-annual physician office visits are excluded.
LDL-C screening rates may be understated because the screenings are sometimes not billed for separately
Figure Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

[51] Preventative care services excludes non-annual physician office visits.

[52] *Ibid.*

More female newly eligible Medicaid expansion enrollees used preventative services than males. The following figure shows 49% of females, age 19 to 32 years old and 30% of males age 19 to 32 years old received preventative services between April 1, 2015, and March 31, 2016.[53] The comparison group showed a similar pattern for preventative services utilization between genders.

Figure 24. Percent of Female and Male Individuals by Age Enrolled in Medicaid Expansion that Utilized Preventative Services between April 1, 2015 and March 31, 2016

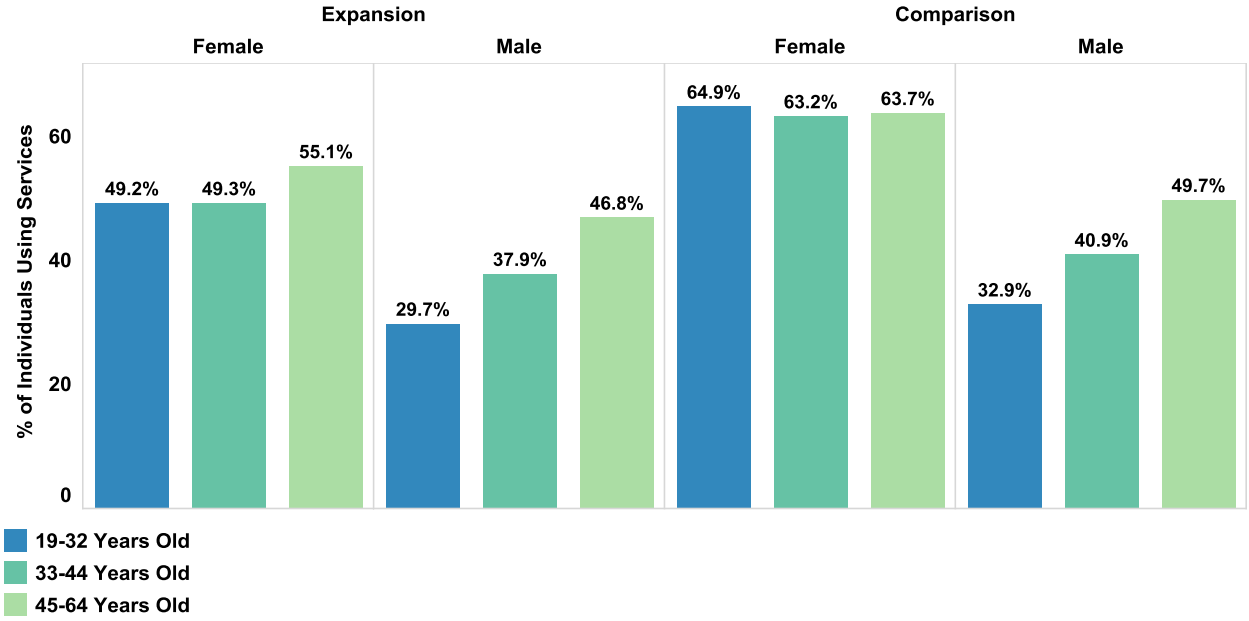


Figure Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017for the purposes of this report.

6.2.4 Most Common Substance Use Disorder and/or Mental Health Services

Thirty one (31%), or 260,504 individuals, of the newly eligible Medicaid expansion enrollees were diagnosed with and/or treated for Substance Use Disorder (SUD) and/or Mental Health (MH) conditions between April 1, 2015, and March 31, 2016. As shown in the following figure, young females, age 19 to 32 years old, represented a smaller percentage of those diagnosed with and/or treated for SUD/MH (25%) as the comparison group females, age 19 to 32 years old (32%). Young males, age 19 to 32 years old, had a greater percentage (30%) of those diagnosed and/or treated for SUD/MH than the comparison group males, age 19 to 32 years old (23%). Males age 33 to 44 years old represented the highest percentage of the newly eligible Medicaid expansion population diagnosed with and/or treated for SUD/MH conditions, at 37%.

[53] *Ibid.*

Figure 25. Number of Individuals Diagnosed with and/or Treated for Substance Use Disorder (SUD)/Mental Health (MH) Conditions between April 1, 2015 and March 31, 2016 by Medicaid Expansion and Comparison Population Groups

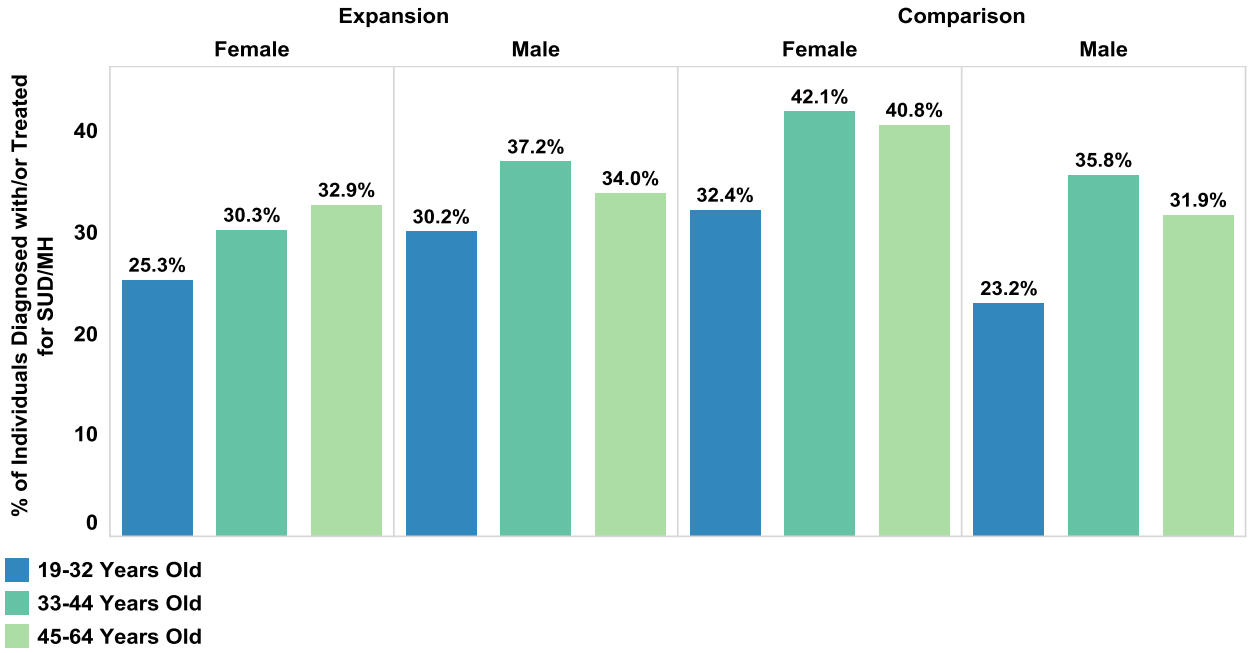


Figure Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

The following figure shows that approximately 48% of the newly eligible Medicaid expansion population who were diagnosed with opioid dependence and/or received treatment for opioid dependence were young adults (ages 19 to 32 years old). In both the comparison and expansion populations, the group least often diagnosed with and/or treated for opioid dependence was older males (ages 45 to 64 years old). Overall, the Medicaid expansion group had higher opioid diagnosis/treatment rates than the comparison group. Specifically, 48,653 Medicaid expansion enrollees were diagnosed with and/or treated for opioid dependence, which represents half (50%) of those diagnosed with SUD.[54]

[54] *Ibid.*

An analysis of diagnose codes on claim and encounter data identified enrollees diagnosed with opioid dependence and/or received treatment for opioid dependence.

Figure 26. Number of Individuals Diagnosed with and/or Treated for Opioid Dependence between April 1, 2015 and March 31, 2016 by Medicaid Expansion and Comparison Population Groups

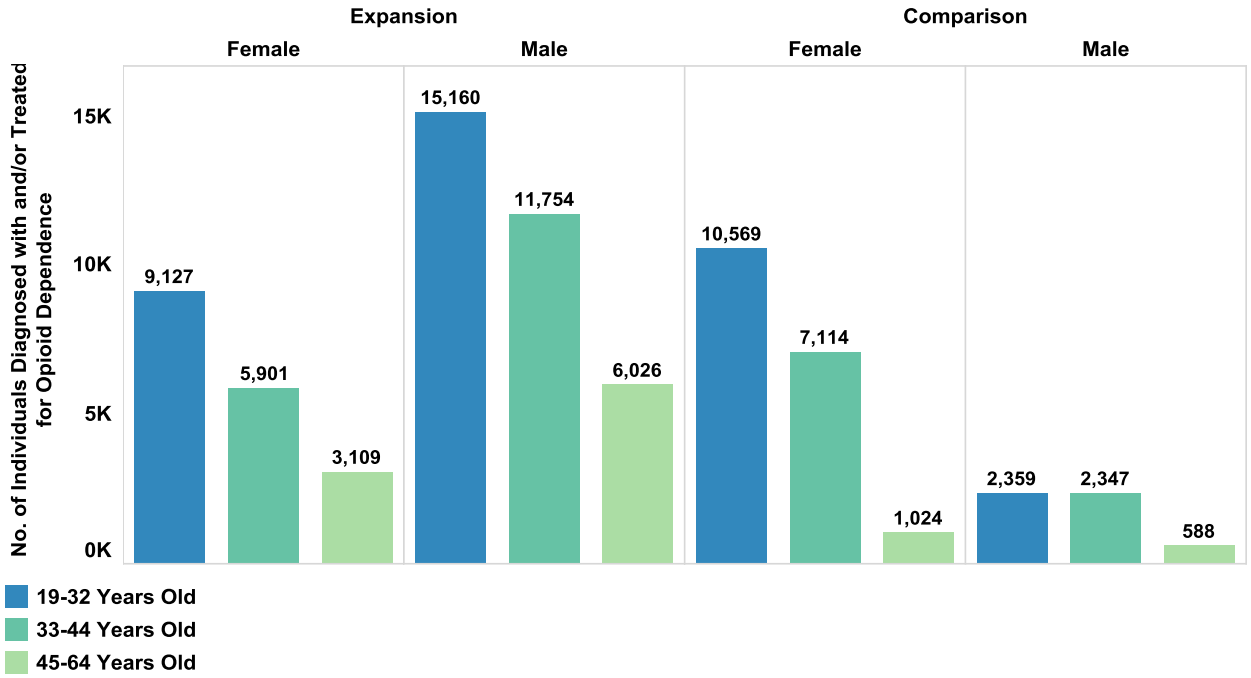


Figure Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

6.2.5 Most Common Hospital Services

Five percent (5%) of the newly eligible Medicaid expansion population were admitted to an acute care hospital between April 1, 2015, and March 31, 2016, and 27% had an emergency department/room (ER) visit. The comparison group had more frequent use of hospitalization at acute care inpatient facilities and ER visits during the same 12-month time period (16% and 37% respectively).

Figure 27 shows the five most common diagnostic groups for the newly eligible Medicaid expansion enrollees that were admitted for inpatient services at acute care inpatient facilities.[55] Multiple diagnoses are summarized into each group. For example:

- Injury, poisoning, and certain other consequences of external causes includes: poisoning by, adverse effect of and overdosing of opium, heroin, methadone, and other opioids; and infection following a procedure or other unclassified complications among other diagnoses.

[55] The inpatient hospitalization percentage is calculated by dividing the number of individuals with the diagnosis over the total number of individuals receiving Inpatient services (40,874 individuals during the reporting period).

- Diseases of the circulatory system include: Congestive Heart Failure (CHF); Chronic Obstructive Pulmonary Disease (COPD); and other complications related to the heart and lung, such as acute subendocardial myocardial infarction, heart attack, and pulmonary embolism among other diagnoses.
- Diseases of the respiratory system include asthma and pneumonia among other diagnoses.
- Pregnancy, childbirth, and puerperium include maternal care for abnormality of pelvic organs and late pregnancy among other diagnoses.
- External causes of morbidity include encounter for other specified aftercare such as testing for hemodialysis, or adjustment for artificial arm, eye, leg among other diagnoses.

Twelve percent (12.4%) of all hospital admissions for newly eligible Medicaid expansion enrollees resulted in a hospital readmission to a general acute care hospital within 30 days after being discharged from an earlier hospital stay.

Figure 27. Five Most Common Diagnoses for Inpatient Hospitalizations among Medicaid Expansion Enrolled Individuals between April 1, 2015 and March 31, 2016

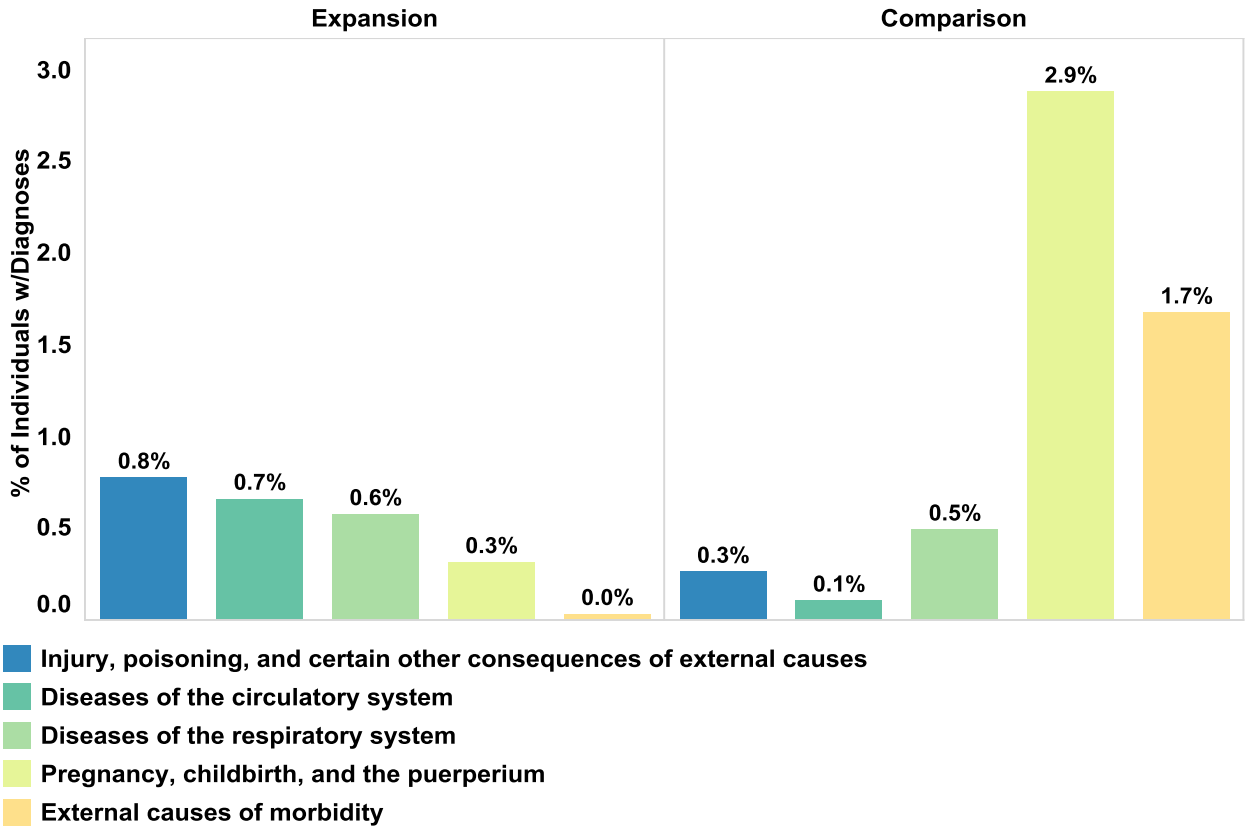


Figure Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

Figure 28 shows the top five most common diagnostic groups for ER visits at acute care inpatient facilities.[56]. Multiple diagnoses are rolled up into each group. For example:

- Symptoms, signs, and abnormal clinical and laboratory findings not elsewhere classified include: abdominal and pelvic pain; and localized swelling, mass and lump of skin and subcutaneous tissue among other diagnoses
- Injury, poisoning, and certain other consequences of external causes include: fracture of lower leg, including ankle; and fracture of shoulder and upper arm among other diagnoses.
- Diseases of the musculoskeletal system and connective tissue include: synovitis and tenosynovitis; and disease of musculoskeletal system among other diagnoses.
- Diseases of the respiratory system includes asthma, chronic and acute respiratory failure, and bronchitis among other diagnoses.
- Diseases of the digestive system include diseases related to tongue, gingivitis and periodontal diseases, and peptic ulcer among other diagnoses.

[56] The emergency room percentage is calculated by dividing the number of individuals with the diagnosis over the total number of individuals receiving emergency room services (228,648 individuals during the reporting period).

Figure 28. Five Most Common Diagnoses for Emergency Room Visits among Medicaid Expansion Enrolled Individuals between April 1, 2015 and March 31, 2016

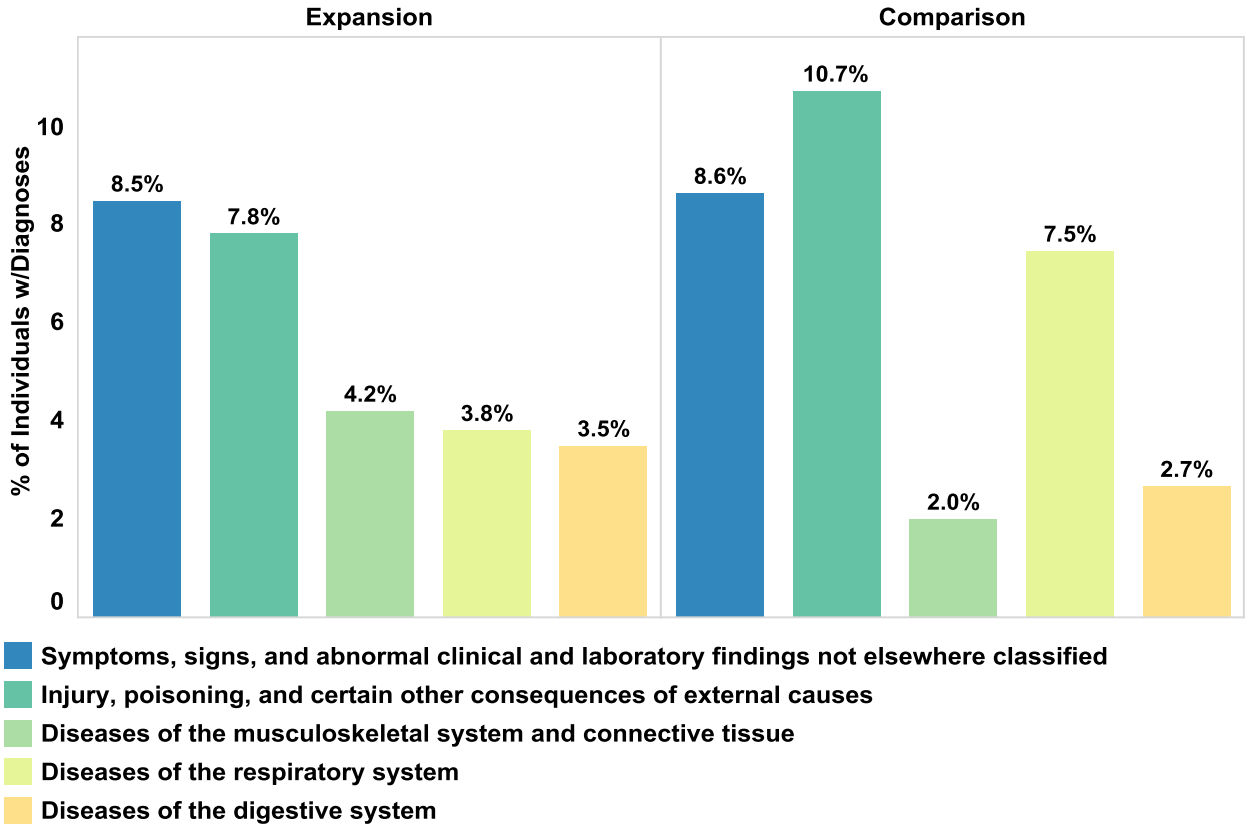


Figure Source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

6.2.6 Most Common Prescribed Drugs

The top five most commonly drug types prescribed to the newly eligible Medicaid expansion population are depicted in the following table.[57] Analgesics and Nonsteroidal Anti-Inflammatory Drugs (NSAIDS) were the most common prescribed drugs for the Medicaid expansion enrollees. Twenty-three (23%) percent of newly eligible Medicaid expansion enrollees were prescribed Analgesics. Seventeen percent (17%) were prescribed NSAIDS, similarly compared to approximately 17.9% of the comparison group.

Table 21. Top Five Most Prescribed Drugs for Medicaid Expansion Enrolled Individuals between April 1, 2015 and March 31, 2016

Drug Type	Percentage of Medicaid Expansion Enrollees with the Prescription Drug	Percentage of Comparison Group with Prescription Drug
Analgesics, Narcotics Short	23.0%	23.8%
Nonsteroidal Anti-Inflammatory Drugs (NSAIDS, such as Ibuprofen, Naproxen, and Celecoxib)	17.6%	17.9%
Bronchodilators, Beta Agonist	15.3%	13.9%
Intranasal Rhinitis Agents	8.6%	7.7%
Macrolides/Ketolides	6.2%	7.0%

Table Sources: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

Retrieved drug type from GHS A Change Healthcare Company, drug search database for Pennsylvania DHS' fee-for-service (FFS) delivery system, available at https://pdllookup.pagov.changehealthcare.com/DrugSearch/.

[57] PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

7. Conclusion

Pennsylvania's first year of Medicaid expansion had a significant impact on the uninsured population, the health care community, state government, and the Commonwealth overall. Data suggests Pennsylvania has seen increased Medicaid enrollment, reduced numbers of uninsured, increased Medicaid expenditures, financial benefits for Pennsylvania's health care providers, and economic growth as a result of expansion.

Increased Medicaid enrollment. With the implementation of Medicaid expansion, 559,851 newly eligible individuals were enrolled in Medicaid expansion by the end of CY 2015. Statewide Medicaid enrollment increased from 2.2 million in December 2014 to over 2.6 million by December 2015. All 67 counties experienced an increase in Medicaid enrollment. By the end of the CY 2015, 21% of the Commonwealth's population, all ages, was enrolled in the Medicaid program. Medicaid expansion enrollees made up approximately 11% of nonelderly adults in Pennsylvania.

Provided comprehensive health care coverage. Medicaid expansion extended Medicaid coverage to many Pennsylvanians who otherwise would not have had comprehensive health care. The new adult benefit package provided by HealthChoices Expansion complies with the Essential Health Benefits established under the ACA for newly eligible adults and with federal parity requirements for behavioral health services.

Reduced numbers of uninsured. In 2015, Pennsylvania's uninsured rate for all ages was 6.4% and the 15th lowest in the U.S. The uninsured rate among nonelderly adults in Pennsylvania decreased three percentage points from 11.7% in 2014 to 8.7% in 2015, which was below the 2015 national average (13.1%).

Increased Medicaid expenditures. Service expenditures for enrollees funded by Medicaid expansion were approximately $2.8 billion in CY 2015 (state and federal funds). Medicaid expansion represented approximately 11% of the total Medicaid service expenditures in CY 2015.

Extended financial benefits for health care providers. Hospitals and retail health care providers (including pharmacies, durable medical equipment, and medical supplies) received the majority (65%) of payments made to providers serving newly eligible Medicaid expansion enrollees.

Decreased hospital uncompensated care. According to data compiled by the Pennsylvania Cost Containment Council (PHC4), uncompensated care for general

acute care hospitals fell by nearly 9% or approximately $92 million in forgone revenue in 2015. Collectively, the non-general acute care hospitals' forgone revenue from uncompensated care declined during 2015 by $19.9 million.

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8. Appendix

Figures and tables on the following pages provide additional information on the Commonwealth's Medicaid expansion in 2015.

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8.1 Report Figures and Tables

Below is a list of the figures and tables contained in this report, and their page number.

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8.2 National Uninsured Rate after Medicaid Expansion

The national uninsured rate decreased to 9.4% (approximately 29.7 million uninsured individuals) in 2015 from 11.6% (approximately 36.7 million uninsured individuals) in 2014 according to the U.S. Census Bureau. This represents a decrease of over two percentage points and seven million individuals. The following maps show the uninsured rates from the U.S. Census Bureau by percent for each state for all ages in 2015.[58] Nationally, the uninsured rate for all ages ranged from 17.1% in Texas to 2.8% percent in Massachusetts.

Figure 29. Uninsured Percent for All Ages in 2015 by State

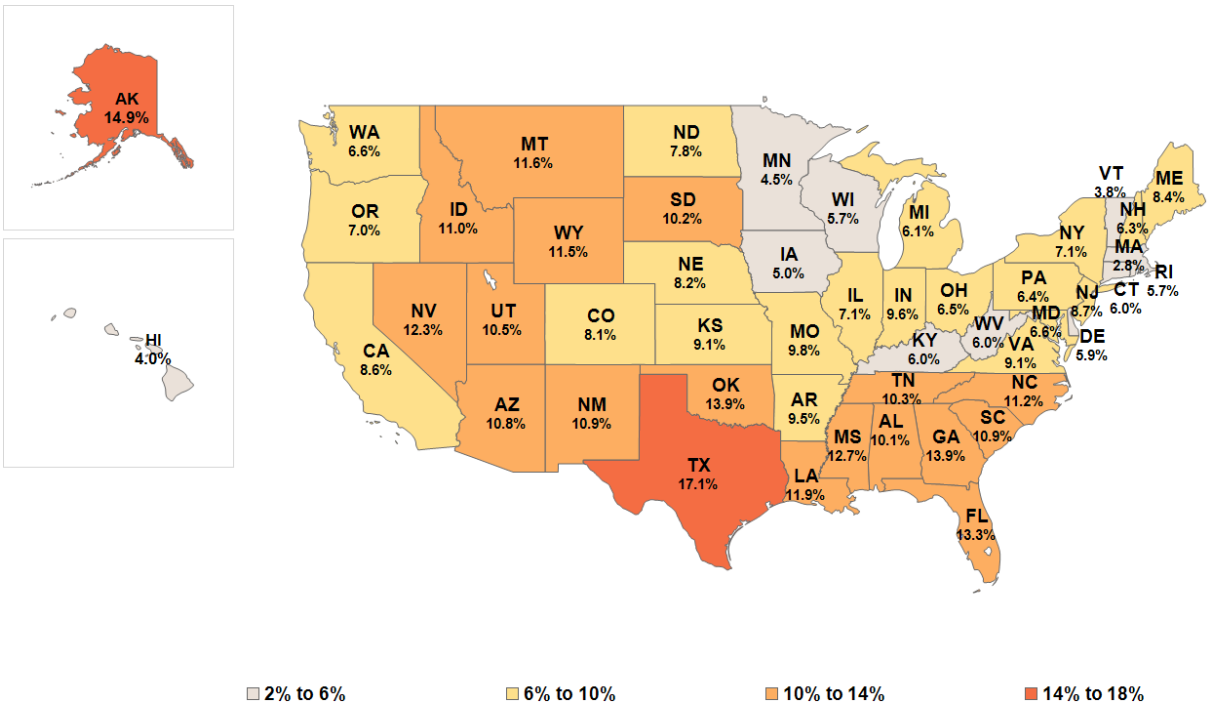

Figure Source: U.S. Census Bureau. 2015 American Community Survey 1-Year Estimates. Retrieved from American Factfinder: https://factfinder.census.gov/.

[58] U.S. Census Bureau. 2015 American Community Survey 1-Year Estimates. Retrieved from American Factfinder: https://factfinder.census.gov/.

The map below shows the uninsured rates for nonelderly adults (18 to 64 year olds) by percent for each state in 2015 from the U.S. Census Bureau.[59] The national average uninsured rate among nonelderly adults (18 to 64 year olds) was 13.1% in 2015. Across the U.S., the uninsured rate for 18 to 64 years old ranged from 23.3% in Texas to 3.9% in Massachusetts. As discussed in Section 2, Pennsylvania's uninsured rate was 6.4% for all ages and 8.7% for nonelderly adults in 2015.

Figure 30. Uninsured Percent for Nonelderly Adults (18 to 64 years old) in 2015 by State

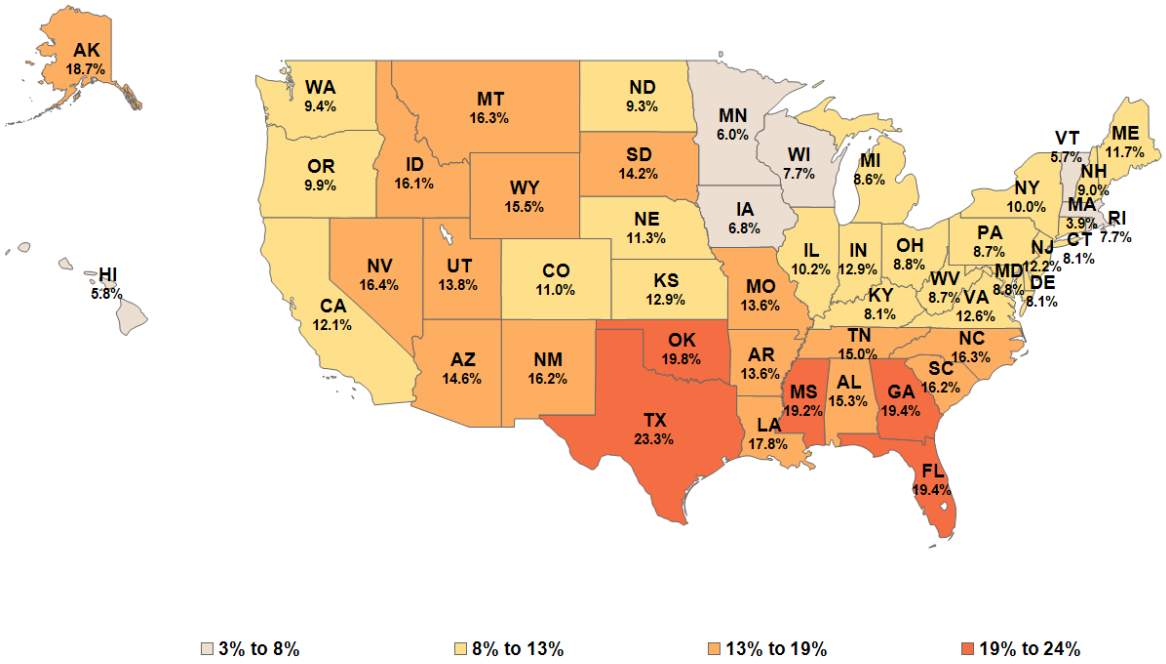

Figure Source: U.S. Census Bureau. 2015 American Community Survey 1-Year Estimates. Retrieved from American Factfinder: https://factfinder.census.gov/.

[59] *Ibid.*

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8.3 Medicaid Enrollment by Eligibility Category and Year-Over-Year Percent Changes

The tables below show Pennsylvania's Medicaid enrollment by seven summary eligibility categories since Calendar Year (CY) 2011, including average monthly count by category, percent of total enrollment, and year-over-year changes as percentage points.

Table 22. Medicaid Enrollment, by Calendar Year and by Eligibility Category (Average Monthly and Percent of Total Enrollment)

Calendar Year	Average Monthly and Percent of Total	Children and Families	Disabled	Elderly	Chronically Ill	Healthy Horizons	SelectPlan for Women/Family Planning State Plan Option*	Group VII Medicaid Expansion	Total	Unduplicated Total
CY11	Avg. Mon.	1,224,118	492,438	152,777	134,217	170,037	97,468	N/A	2,271,055	2,231,188
	% of Total	*53.9%*	*21.7%*	*6.7%*	*5.9%*	*7.5%*	*4.3%*	N/A	*100%*	
CY12	Avg. Mon.	1,209,924	509,958	153,588	115,549	193,217	97,704	N/A	2,279,941	2,236,951
	% of Total	*53.1%*	*22.4%*	*6.7%*	*5.1%*	*8.5%*	*4.3%*	N/A	*100%*	
CY13	Avg. Mon.	1,209,918	523,383	155,268	76,910	211,747	97,265	N/A	2,274,490	2,241,497
	% of Total	*53.2%*	*23.0%*	*6.8%*	*3.4%*	*9.3%*	*4.3%*	N/A	*100%*	
CY14	Avg. Mon.	*1,246,739	527,076	156,628	80,522	219,809	88,566	*137	2,319,453	2,286,431
	% of Total	*53.8%*	*22.7%*	*6.8%*	*3.5%*	*9.5%*	*3.8%*	*0.0%*	*100%*	
CY15	Avg. Mon.	*1,240,116	518,616	161,987	5,197	216,726	44,821	484,323	2,671,785	2,602,539
	% of Total	*46.4%*	*19.4%*	*6.1%*	*0.2%*	*8.1%*	*1.7%*	*18.1%*	*100%*	
CY16	Avg. Mon.	1,256,257	503,937	171,096	5,569	172,661**	11,526	714,633	2,835,679	2,789,285
	% of Total	*44.3%*	*17.8%*	*6.0%*	*0.2%*	*6.1%*	*0.4%*	*25.2%*	*100%*	

Totals are approximate due to rounding.

** As of July 1, 2015, SelectPlan for Women participants (who were not otherwise eligible for Medicaid) are covered under the Family Planning Services program.*

*** The large decrease is due to modifications to the Healthy Horizons Disabled category, which are described in Operations Memorandum #16-03-05.*

Table 23. Year-Over-Year Percent Changes in Average Monthly Medicaid Enrollment by Calendar Year and by Eligibility Category

Calendar Year	% Change in Monthly Average	Children and Families	Disabled	Elderly	Chronically Ill	Healthy Horizons	SelectPlan for Women/Family Planning State Plan Option*	Group VII Medicaid Expansion	Total	Unduplicated Total
CY12	Avg. Mon.	-1.2%	+3.6%	+0.5%	-13.9%	+13.6%	+0.2%	N/A	+0.4%	+0.3%
CY13	Avg. Mon.	0.0%	+2.6%	+1.1%	-33.4%	+9.6%	-0.4%	N/A	-0.2%	+0.2%

Calendar Year	% Change in Monthly Average	Children and Families	Disabled	Elderly	Chronically Ill	Healthy Horizons	SelectPlan for Women/Family Planning State Plan Option*	Group VII Medicaid Expansion	Total	Unduplicated Total
CY14	Avg. Mon.	+3.0%	+0.7%	+0.9%	+4.7%	+3.8%	-8.9%	N/A	+2.0%	+2.0%
CY15	Avg. Mon.	-0.5%	-1.6%	+3.4%	-93.5%	-1.4%	-49.4%	N/A	+15.2%	+13.8%
CY16	Avg. Mon.	+1.3%	-2.8%	+5.6%	+7.2%	-20.3%**	-74.3%	+47.6%	+6.1%	+7.2%

Totals are approximate due to rounding.

** As of July 1, 2015, SelectPlan for Women participants (who were not otherwise eligible for Medicaid are covered under the Family Planning Services program.*

*** The large decrease is due to modifications to the Healthy Horizons Disabled category, which are described in Operations Memorandum #16-03-05.*

Source for tables above: PA DHS. Calculated for Calendar Year basis from "Monthly Eligibility from Data Warehouse - September 2016.xlsx" provided by DHS on October 25, 2016 for the purposes of this report.

The tables below show Medicaid enrollment by seven summary eligibility categories since SFY 2007-2008, including average monthly count by category and percent of total enrollment, then the year-over-year changes as percentage points.

Table 24. Medicaid Enrollment, by State Fiscal Year and by Eligibility Category (Average Monthly and Percent of Total Enrollment)

State Fiscal Year	Average Monthly and Percent of Total	Children and families	Disabled	Elderly	Chronically Ill	Healthy Horizons	SelectPlan for Women/ Family Planning State Plan Option*	Group VII Medicaid Expansion	Grand Total	Unduplicated Total
SFY08	Avg. Mon.	1,080,354	415,091	142,198	104,961	130,323	10,862	N/A	1,881,073	2,282,592
	% of Total	57.4%	22.1%	7.6%	5.6%	6.9%	0.6%	N/A	100.0%	
SFY09	Avg. Mon.	1,111,370	433,459	142,222	110,868	140,262	47,706	N/A	1,985,888	2,389,603
	% of Total	56.0%	21.8%	7.2%	5.6%	7.1%	2.4%	N/A	100.0%	
SFY10	Avg. Mon.	1,169,842	456,705	144,487	122,341	151,238	73,276	N/A	2,117,890	2,507,350
	% of Total	55.2%	21.6%	6.8%	5.8%	7.1%	3.5%	N/A	100.0%	
SFY11	Avg. Mon.	1,214,974	481,015	151,502	131,684	163,781	91,982	N/A	2,234,938	2,637,224
	% of Total	54.4%	21.5%	6.8%	5.9%	7.3%	4.1%	N/A	100.0%	
SFY12	Avg. Mon.	1,217,922	501,777	152,741	135,060	173,350	98,011	N/A	2,278,861	2,721,213
	% of Total	53.4%	22.0%	6.7%	5.9%	7.6%	4.3%	N/A	100.0%	
SFY13	Avg. Mon.	1,209,705	517,467	154,785	86,506	211,707	97,726	N/A	2,277,894	2,697,321
	% of Total	53.1%	22.7%	6.8%	3.8%	9.3%	4.3%	N/A	100.0%	

State Fiscal Year	Average Monthly and Percent of Total	Children and families	Disabled	Elderly	Chronically Ill	Healthy Horizons	SelectPlan for Women/ Family Planning State Plan Option*	Group VII Medicaid Expansion	Grand Total	Unduplicated Total
SFY14	Avg. Mon.	1,224,458	526,748	155,725	78,540	215,022	93,086	2	2,293,580	2,743,522
	% of Total	53.4%	23.0%	6.8%	3.4%	9.4%	4.1%	0.0%	100.0%	
SFY15	Avg. Mon.	*1,245,504	525,250	157,987	42,967	221,917	78,138	*202,890	2,474,653	2,963,579
	% of Total	50.3%	21.2%	6.4%	1.7%	9.0%	3.2%	8.2%	100.0%	
SFY16	Avg. Mon.	1,248,129	509,545	168,576	5,584	196,202**	15,869	631,379	2,775,284	3,239,188
	% of Total	45.0%	18.4%	6.1%	0.2%	7.1%	0.6%	22.8%	100.0%	

Totals are approximate due to rounding.

**As of July 1, 2015, SelectPlan for Women participants (who were not otherwise eligible for Medicaid) are covered under the Family Planning Services program.*

***The large decrease is due to modifications to the Healthy Horizons Disabled category, which are described in Operations Memorandum #16-03-05.*

Table 25. Year-Over-Year Percent Changes in Average Monthly Medicaid Enrollment by State Fiscal Year and by Eligibility Category

State Fiscal Year	% Change in Monthly Average	Children and Families	Disabled	Elderly	Chronically Ill	Healthy Horizons	SelectPlan for Women/ Family Planning State Plan Option*	Group VII Medicaid Expansion	Grand Total	Unduplicated Total
SFY09	Avg. Mon.	+2.9%	+4.4%	0.0%	+5.6%	+7.6%	+339.2%	N/A	+5.6%	+4.7%
SFY10	Avg. Mon.	+5.3%	+5.4%	+1.6%	+10.3%	+7.8%	+53.6%	N/A	+6.6%	+4.9%
SFY11	Avg. Mon.	+3.9%	+5.3%	+4.9%	+7.6%	+8.3%	+25.5%	N/A	+5.5%	+5.2%
SFY12	Avg. Mon.	+0.2%	+4.3%	+0.8%	+2.6%	+5.8%	+6.6%	N/A	+2.0%	+3.2%
SFY13	Avg. Mon.	-0.7%	+3.1%	+1.3%	-36.0%	+22.1%	-0.3%	N/A	0.0%	-0.9%
SFY14	Avg. Mon.	+1.2%	+1.8%	+0.6%	-9.2%	+1.6%	-4.7%	N/A	+0.7%	+1.7%
SFY15	Avg. Mon.	+1.7%	-0.3%	+1.5%	-45.3%	+3.2%	-16.1%	N/A	+7.9%	+8.0%
SFY16	Avg. Mon.	+0.2%	-3.0%	+6.7%	-87.0%	-11.6%**	-79.7%	+211.2%	+12.1%	+9.3%

**As of July 1, 2015, SelectPlan for Women participants (who were not otherwise eligible for Medicaid) are covered under the Family Planning Services program.*

***The large decrease is due to modifications to the Healthy Horizons Disabled category, which are described in Operations Memorandum #16-03-05.*

Source for tables above: PA DHS. Retrieved from 'Monthly Eligibility from Data Warehouse - September 2016.xlsx' provided by DHS on October 25, 2016 for the purposes of this report.

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8.4 Medicaid Enrollment by County from July 2014 to June 2016

The table below contains Pennsylvania's Medicaid enrolled persons by county and by month from July 2014 to June 2015. As of July 2014, a new methodology, to acknowledge Medicaid persons, eliminates duplication of persons moving from county to county in a given month. Medicaid enrollment numbers include those served in HealthChoices, FFS, and the PCO.

Table 26. Medicaid Enrolled Individuals from July 2014 to June 2015 by County

County	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
STATE TOTAL	**2,251,385**	**2,248,843**	**2,260,095**	**2,264,683**	**2,251,811**	**2,256,192**	**2,344,722**	**2,395,527**	**2,464,653**	**2,506,704**	**2,537,427**	**2,569,794**
Adams	11,942	11,969	12,105	12,086	12,056	12,145	12,815	13,079	13,758	14,053	14,161	14,321
Allegheny	195,063	194,069	194,878	194,785	194,034	193,875	199,083	202,767	209,082	213,673	216,894	219,476
Armstrong	13,031	12,990	12,952	12,864	12,754	12,783	13,356	13,710	14,108	14,314	14,488	14,597
Beaver	29,736	29,570	29,603	29,708	29,519	29,634	31,050	31,739	32,589	33,016	33,241	33,605
Bedford	9,001	8,977	9,027	9,051	9,026	9,123	9,753	9,994	10,270	10,432	10,506	10,564
Berks	75,603	75,543	75,917	75,914	75,305	75,357	78,401	79,789	81,834	83,136	84,119	85,131
Blair	26,560	26,482	26,642	26,734	26,656	26,678	27,916	28,564	29,299	29,721	30,039	30,328
Bradford	10,752	10,740	10,823	10,864	10,757	10,773	11,225	11,464	11,799	11,998	12,078	12,263
Bucks	58,928	59,151	59,218	59,500	59,001	59,000	61,297	62,768	65,136	67,229	68,414	69,481
Butler	21,114	21,038	21,023	21,022	20,850	20,856	21,689	22,198	23,224	23,697	23,850	24,112
Cambria	27,140	27,166	27,301	27,282	27,140	27,221	28,458	29,121	29,875	30,240	30,631	30,728
Cameron	1,139	1,131	1,133	1,137	1,133	1,145	1,198	1,220	1,237	1,235	1,243	1,268
Carbon	10,039	10,040	10,153	10,162	10,085	10,106	10,696	10,924	11,304	11,553	11,632	11,691
Centre	11,902	11,869	11,890	11,938	11,822	11,882	12,581	13,067	13,368	13,587	13,650	13,833
Chester	40,345	40,440	40,751	40,940	40,764	40,959	42,989	44,079	45,566	46,773	47,735	48,437
Clarion	6,735	6,699	6,747	6,737	6,698	6,730	7,047	7,290	7,481	7,560	7,606	7,640
Clearfield	16,943	16,906	16,902	16,910	16,954	16,957	17,769	18,204	18,666	18,908	19,077	19,165
Clinton	7,143	7,145	7,147	7,129	7,132	7,142	7,426	7,602	7,781	7,844	7,955	8,029

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County	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Columbia	10,120	10,080	10,130	10,092	10,038	10,018	10,481	10,776	11,092	11,274	11,457	11,520
Crawford	16,937	16,888	16,952	16,969	16,842	16,892	17,645	17,892	18,365	18,624	18,663	18,776
Cumberland	23,689	23,793	24,092	24,201	24,113	24,293	25,516	26,291	27,191	27,624	27,763	28,208
Dauphin	48,975	48,833	49,009	49,387	49,307	49,715	51,725	52,966	54,402	56,147	58,344	59,609
Delaware	88,510	88,146	88,716	89,181	88,747	89,119	88,598	89,393	91,392	93,921	96,136	98,577
Elk	5,142	5,103	5,123	5,159	5,144	5,105	5,291	5,395	5,566	5,622	5,627	5,668
Erie	63,930	63,686	63,896	63,931	63,552	63,754	67,015	68,506	70,047	71,021	71,710	72,357
Fayette	35,237	35,070	35,194	35,073	34,913	34,987	36,587	37,396	38,211	38,628	38,944	39,460
Forest	909	911	910	908	909	913	995	1,020	1,037	1,047	1,048	1,067
Franklin	21,071	21,131	21,462	21,537	21,488	21,535	22,779	23,420	24,156	24,622	24,890	25,270
Fulton	2,701	2,692	2,683	2,662	2,618	2,626	2,776	2,862	2,915	2,905	2,937	2,950
Greene	7,689	7,638	7,659	7,617	7,597	7,573	7,891	8,081	8,249	8,375	8,466	8,619
Huntingdon	8,229	8,189	8,211	8,188	8,153	8,158	8,529	8,752	9,019	9,095	9,182	9,240
Indiana	13,374	13,450	13,453	13,499	13,376	13,526	14,494	14,895	15,268	15,470	15,622	15,835
Jefferson	9,135	9,157	9,193	9,176	9,098	9,125	9,499	9,678	9,955	10,161	10,263	10,319
Juniata	3,442	3,412	3,459	3,492	3,429	3,467	3,644	3,728	3,825	3,862	3,852	3,849
Lackawanna	41,780	41,652	41,779	41,856	41,648	41,830	43,606	44,703	46,012	46,694	47,232	47,806
Lancaster	74,806	74,624	75,017	75,348	74,831	75,323	77,951	79,640	82,884	84,348	85,020	85,913
Lawrence	17,722	17,706	17,861	17,828	17,745	17,797	18,730	19,197	19,648	19,984	20,135	20,376
Lebanon	21,194	21,110	21,447	21,569	21,442	21,611	22,725	23,393	24,195	24,510	24,840	25,153
Lehigh	66,005	66,134	66,682	66,897	66,911	66,969	70,301	71,929	73,940	75,025	75,945	77,071
Luzerne	65,180	65,032	65,379	65,683	65,235	65,285	67,524	68,982	71,284	72,614	73,569	74,561
Lycoming	20,749	20,635	20,747	20,873	20,657	20,782	21,754	22,324	22,905	23,322	23,421	23,732
McKean	9,301	9,308	9,308	9,310	9,284	9,293	9,727	9,916	10,114	10,246	10,351	10,460
Mercer	23,421	23,351	23,348	23,329	23,186	23,199	24,276	24,658	25,197	25,465	25,652	25,921
Mifflin	9,349	9,341	9,384	9,364	9,316	9,335	9,808	10,008	10,180	10,266	10,335	10,420

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County	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Monroe	28,200	28,181	28,234	28,293	28,053	27,978	29,419	30,218	31,248	31,597	32,006	32,370
Montgomery	78,760	78,892	79,664	79,703	79,607	80,147	84,784	87,339	90,537	92,447	93,733	95,091
Montour	2,596	2,605	2,639	2,613	2,566	2,581	2,719	2,784	2,869	2,853	2,841	2,884
Northampton	41,233	41,110	41,870	41,787	41,477	42,025	44,308	45,766	47,230	47,972	48,420	49,303
Northumberland	17,378	17,375	17,505	17,624	17,539	17,591	18,335	18,918	19,465	19,743	20,002	20,265
Perry	5,897	5,844	5,905	5,890	5,904	5,882	6,185	6,353	6,634	6,763	6,861	6,898
Philadelphia	528,233	529,093	531,126	532,274	528,783	528,758	546,200	555,883	570,314	577,749	583,650	590,970
Pike	7,869	7,836	7,873	7,975	7,968	8,011	8,493	8,803	9,121	9,260	9,404	9,447
Potter	3,365	3,344	3,390	3,364	3,325	3,327	3,467	3,610	3,726	3,791	3,816	3,842
Schuylkill	27,302	27,307	27,417	27,478	27,391	27,425	28,556	29,171	29,863	30,277	30,570	30,843
Snyder	5,840	5,846	5,887	5,883	5,837	5,853	6,157	6,287	6,455	6,559	6,562	6,645
Somerset	12,382	12,408	12,479	12,408	12,349	12,460	13,330	13,732	14,087	14,250	14,367	14,464
Sullivan	982	960	978	978	962	972	1,024	1,035	1,069	1,103	1,097	1,103
Susquehanna	6,087	6,024	6,105	6,114	6,092	6,067	6,279	6,498	6,768	6,894	6,971	7,049
Tioga	6,924	6,943	6,983	7,060	7,015	7,009	7,463	7,636	7,893	8,051	8,177	8,298
Union	4,863	4,845	4,929	4,945	4,899	4,864	5,063	5,146	5,197	5,247	5,287	5,341
Venango	11,247	11,233	11,246	11,225	11,078	11,092	11,643	11,895	12,152	12,276	12,394	12,486
Warren	7,066	7,079	7,056	7,092	7,043	7,077	7,396	7,620	7,833	7,841	7,896	8,011
Washington	30,168	30,124	30,219	30,290	30,082	30,060	31,577	32,452	33,355	33,804	34,188	34,618
Wayne	8,228	8,184	8,150	8,253	8,229	8,189	8,706	9,011	9,263	9,347	9,362	9,401
Westmoreland	54,673	54,600	54,888	55,038	54,960	55,065	58,128	59,492	60,823	61,538	61,903	62,482
Wyoming	4,360	4,353	4,315	4,322	4,348	4,360	4,586	4,733	4,899	4,973	5,040	5,149
York	64,441	64,264	64,933	65,449	64,993	64,919	67,637	69,127	71,803	73,909	75,551	76,823

Totals are approximate due to rounding.

Table Source: PA DHS. DHS' Medical Assistance, Food Stamps and Cash Assistance Statistics Report, April 2016 data as of May 10, 2016. Retrieved from: http://listserv.dpw.state.pa.us/Scripts/wa.exe?A1=ind16&L=ma-food-stamps-and-cash-stats.

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The table below contains the Medicaid enrolled persons by county and by month from July 2015 to June 2016 (State Fiscal Year 2016). Medicaid enrollment numbers include those served in HealthChoices, FFS, and the PCO.

Table 27. Medicaid Enrolled Individuals from July 2015 to June 2016 by County

County	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
STATE TOTAL	**2,592,693**	**2,611,818**	**2,635,294**	**2,650,622**	**2,661,843**	**2,696,112**	**2,711,066**	**2,727,218**	**2,752,820**	**2,752,946**	**2,765,510**	**2,772,011**
Adams	14,517	14,630	14,805	14,917	14,914	15,241	15,327	15,361	15,400	15,383	15,461	15,477
Allegheny	220,496	222,085	222,810	223,714	224,360	227,382	229,405	231,861	233,501	232,992	233,240	233,443
Armstrong	14,778	14,937	15,072	15,161	15,206	15,529	15,646	15,690	15,814	15,858	15,858	15,884
Beaver	33,829	34,121	34,194	34,428	34,574	35,074	35,268	35,408	35,693	35,604	35,742	35,640
Bedford	10,585	10,620	10,712	10,815	10,897	11,023	11,035	11,079	11,108	11,089	11,179	11,176
Berks	85,810	86,396	87,106	87,366	87,123	88,242	88,438	88,924	89,862	89,892	90,217	90,478
Blair	30,572	30,861	31,011	31,065	31,218	31,649	31,831	31,989	32,245	32,276	32,482	32,488
Bradford	12,429	12,611	12,776	12,909	12,917	13,135	13,259	13,399	13,571	13,603	13,705	13,746
Bucks	70,379	70,995	71,772	72,254	72,760	74,088	74,612	75,201	76,224	75,900	76,055	76,129
Butler	24,400	24,562	24,798	24,946	24,998	25,450	25,755	25,944	26,173	26,175	26,318	26,386
Cambria	31,186	31,429	31,599	31,708	31,874	32,505	32,703	32,967	33,313	33,392	33,565	33,674
Cameron	1,291	1,279	1,281	1,280	1,287	1,302	1,330	1,335	1,339	1,358	1,353	1,375
Carbon	11,775	11,923	11,954	12,022	12,141	12,325	12,465	12,505	12,628	12,683	12,740	12,828
Centre	13,992	14,080	14,133	14,208	14,270	14,602	14,792	14,903	14,970	14,748	14,767	14,726
Chester	48,973	49,081	49,654	49,851	50,117	51,127	51,570	52,092	52,582	52,216	52,294	52,454
Clarion	7,682	7,769	7,806	7,797	7,809	7,991	7,998	8,023	8,142	8,145	8,138	8,116
Clearfield	19,310	19,565	19,698	19,706	19,866	20,221	20,428	20,572	20,819	20,821	20,822	20,846
Clinton	8,090	8,140	8,214	8,251	8,229	8,349	8,402	8,512	8,601	8,671	8,673	8,713
Columbia	11,617	11,753	11,877	11,946	11,985	12,177	12,225	12,333	12,340	12,315	12,347	12,367
Crawford	18,905	19,029	19,028	19,033	19,044	19,367	19,516	19,637	19,832	19,809	19,954	19,871
Cumberland	28,522	28,859	29,263	29,688	29,736	30,365	30,680	30,864	31,129	31,256	31,463	31,449
Dauphin	59,561	60,096	60,718	61,191	61,681	62,634	62,761	63,500	64,762	64,319	64,219	64,824

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County	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Delaware	104,893	106,075	110,607	111,494	111,922	110,353	111,452	112,207	113,549	113,332	113,947	114,316
Elk	5,709	5,720	5,732	5,716	5,701	5,795	5,814	5,848	5,922	5,917	5,878	5,917
Erie	72,812	73,451	73,672	73,973	74,259	75,118	75,315	75,484	76,043	76,139	76,320	76,340
Fayette	39,710	39,886	40,131	40,251	40,542	41,162	41,300	41,497	41,881	41,885	42,233	42,357
Forest	1,082	1,076	1,072	1,086	1,087	1,107	1,113	1,112	1,108	1,099	1,114	1,116
Franklin	25,650	25,938	26,118	26,272	26,366	26,744	26,778	27,042	27,386	27,376	27,493	27,672
Fulton	2,976	3,013	3,009	3,037	3,069	3,137	3,121	3,146	3,144	3,127	3,144	3,173
Greene	8,707	8,842	8,963	9,015	9,042	9,211	9,262	9,337	9,545	9,558	9,665	9,758
Huntingdon	9,273	9,273	9,270	9,322	9,386	9,519	9,634	9,631	9,748	9,790	9,814	9,737
Indiana	16,044	16,264	16,421	16,490	16,580	16,852	17,075	17,180	17,329	17,423	17,526	17,683
Jefferson	10,461	10,551	10,605	10,638	10,678	10,805	10,885	10,925	11,032	11,091	11,140	11,219
Juniata	3,857	3,897	3,905	3,884	3,910	3,990	4,026	4,037	4,075	4,058	4,122	4,123
Lackawanna	48,369	48,744	49,398	49,729	50,016	50,892	51,259	51,621	52,230	52,272	52,449	52,492
Lancaster	86,648	87,336	87,931	88,150	88,402	89,347	89,596	90,043	91,090	90,662	90,912	91,111
Lawrence	20,602	20,883	20,966	21,041	21,084	21,388	21,508	21,602	21,768	21,770	21,894	21,965
Lebanon	25,353	25,710	25,860	26,007	26,016	26,522	26,690	26,860	27,144	27,112	27,245	27,306
Lehigh	77,694	78,443	79,172	79,650	79,958	81,084	81,403	81,802	82,251	82,316	82,698	82,446
Luzerne	75,255	75,925	76,756	77,358	77,805	79,007	79,481	80,223	81,265	81,481	81,986	82,293
Lycoming	24,010	24,363	24,546	24,637	24,674	25,194	25,427	25,575	25,921	26,136	26,252	26,422
McKean	10,543	10,671	10,662	10,703	10,727	10,859	10,834	10,849	10,962	11,028	11,106	11,100
Mercer	26,113	26,417	26,523	26,596	26,767	27,243	27,318	27,520	27,720	27,613	27,648	27,687
Mifflin	10,544	10,638	10,657	10,685	10,701	10,821	10,834	10,809	10,882	10,868	10,931	10,961
Monroe	32,674	33,040	33,156	33,308	33,519	34,108	34,328	34,445	34,822	34,909	35,217	35,375
Montgomery	96,349	97,438	98,544	99,159	99,955	101,517	102,220	102,825	104,002	104,089	104,343	104,285
Montour	2,891	2,932	2,965	2,965	2,999	3,040	3,020	3,052	3,057	3,050	3,075	3,097
Northampton	49,763	50,179	50,746	51,063	51,356	52,315	52,614	52,960	53,482	53,434	53,699	53,841

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County	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Northumberland	20,402	20,706	20,861	21,075	21,153	21,491	21,612	21,762	21,943	21,938	22,029	22,066
Perry	6,932	6,953	6,998	7,030	7,055	7,161	7,241	7,274	7,290	7,263	7,277	7,305
Philadelphia	596,362	601,167	605,740	610,152	612,579	618,386	620,072	622,019	626,310	627,905	632,636	635,206
Pike	9,597	9,712	9,878	9,912	9,977	10,155	10,198	10,340	10,432	10,427	10,458	10,544
Potter	3,862	3,907	3,918	3,938	3,940	4,048	4,098	4,141	4,217	4,244	4,282	4,305
Schuylkill	31,250	31,558	31,709	31,992	32,132	32,587	32,728	32,823	33,031	33,081	33,336	33,389
Snyder	6,702	6,731	6,749	6,707	6,643	6,755	6,745	6,789	6,811	6,727	6,781	6,768
Somerset	14,638	14,729	14,923	15,046	15,107	15,419	15,590	15,618	15,725	15,770	15,911	15,887
Sullivan	1,106	1,117	1,126	1,171	1,174	1,170	1,152	1,148	1,166	1,174	1,178	1,143
Susquehanna	7,168	7,267	7,403	7,425	7,538	7,641	7,702	7,790	7,886	7,938	8,025	8,060
Tioga	8,423	8,522	8,597	8,662	8,764	8,971	9,134	9,185	9,300	9,379	9,491	9,569
Union	5,391	5,366	5,436	5,435	5,506	5,561	5,571	5,571	5,660	5,647	5,684	5,676
Venango	12,566	12,701	12,790	12,852	12,909	13,072	13,050	13,114	13,237	13,262	13,260	13,253
Warren	8,062	8,185	8,230	8,233	8,273	8,437	8,492	8,586	8,645	8,685	8,737	8,779
Washington	34,930	35,197	35,478	35,802	36,060	36,569	36,842	37,043	37,502	37,656	37,863	37,980
Wayne	9,484	9,580	9,564	9,657	9,728	9,941	10,062	10,058	10,093	10,145	10,108	10,142
Westmoreland	62,920	63,417	63,935	64,380	64,818	65,935	66,199	66,437	66,988	66,986	67,238	67,256
Wyoming	5,215	5,302	5,364	5,388	5,433	5,519	5,614	5,686	5,770	5,763	5,803	5,807
York	77,507	78,175	78,927	79,280	79,527	80,386	81,211	82,103	83,408	82,916	82,970	82,994

Totals are approximate due to rounding.

Table source: PA DHS. DHS' Medical Assistance, Food Stamps and Cash Assistance Statistics Report, April 2016 data as of May 10, 2016. Retrieved from: http://listserv.dpw.state.pa.us/Scripts/wa.exe?A1=ind16&L=ma-food-stamps-and-cash-stats.

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8.5 Medicaid Expansion Enrollment by County from January 2015 to December 2015

The table below contains the number of newly eligible Medicaid expansion enrollees (i.e., medical assistance categories MG 91 and PCO 91) by county and by month (at the end of the month from January 2015 to December 2015). Enrollment numbers include those served in HealthChoices Expansion, FFS, and the PCOs.

Table 28. Medicaid Expansion Enrollment Count from January 2015 to December 2015 by County

County	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
STATE TOTAL	**137,045**	**224,064**	**287,141**	**358,068**	**404,505**	**428,992**	**452,878**	**472,774**	**489,803**	**508,395**	**530,854**	**559,851**
Adams	1,010	1,700	2,175	2,771	3,149	3,359	3,529	3,700	3,786	3,884	4,090	4,318
Allegheny	14,017	23,452	28,615	35,290	40,112	42,585	44,978	46,732	48,322	49,879	51,930	54,821
Armstrong	1,065	1,643	2,141	2,673	2,978	3,118	3,283	3,426	3,575	3,729	3,879	4,103
Beaver	2,186	3,467	4,320	5,132	5,659	5,950	6,214	6,418	6,624	6,826	7,077	7,404
Bedford	745	1,129	1,487	1,868	2,087	2,207	2,317	2,414	2,530	2,642	2,784	2,905
Berks	7,085	11,036	13,360	16,268	18,140	18,959	19,853	20,639	21,253	21,851	22,499	23,556
Blair	1,993	2,914	3,728	4,603	5,204	5,512	5,811	6,087	6,292	6,439	6,711	7,039
Bradford	660	1,153	1,445	1,819	2,052	2,224	2,368	2,509	2,619	2,738	2,793	2,925
Bucks	4,770	7,946	9,838	12,487	14,231	14,983	15,756	16,321	16,857	17,551	18,472	19,555
Butler	1,169	1,859	2,498	3,220	3,733	4,007	4,255	4,447	4,630	4,814	5,049	5,359
Cambria	1,965	2,791	3,744	4,693	5,258	5,566	5,895	6,117	6,371	6,608	6,877	7,244
Cameron	98	149	178	215	240	263	284	300	315	313	334	345
Carbon	1,037	1,648	2,013	2,502	2,773	2,887	3,007	3,089	3,192	3,293	3,427	3,583
Centre	889	1,489	2,003	2,489	2,832	3,095	3,369	3,582	3,726	3,853	4,006	4,278
Chester	2,890	4,972	6,223	7,658	8,724	9,331	9,775	10,158	10,530	10,858	11,387	12,150
Clarion	446	728	936	1,120	1,235	1,311	1,366	1,434	1,507	1,560	1,635	1,716
Clearfield	1,190	1,866	2,399	2,919	3,261	3,505	3,815	3,974	4,118	4,180	4,349	4,622
Clinton	472	772	971	1,198	1,347	1,441	1,504	1,584	1,620	1,680	1,754	1,843
Columbia	910	1,412	1,797	2,195	2,468	2,595	2,729	2,858	2,971	3,065	3,173	3,325

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County	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Crawford	1,249	1,902	2,451	3,063	3,398	3,549	3,738	3,938	4,041	4,169	4,334	4,520
Cumberland	1,794	2,783	3,739	4,810	5,488	5,829	6,161	6,442	6,750	7,019	7,335	7,828
Dauphin	3,466	5,319	6,816	8,380	9,796	10,569	11,074	11,615	12,138	12,671	13,228	14,082
Delaware	8,834	15,080	22,492	27,038	30,046	31,468	32,875	33,834	34,697	35,693	36,953	38,585
Elk	229	385	527	663	721	755	799	850	857	880	906	961
Erie	3,888	6,373	8,055	9,872	10,938	11,529	12,072	12,596	12,978	13,509	14,001	14,685
Fayette	2,607	3,789	4,639	5,662	6,313	6,757	7,096	7,431	7,848	8,090	8,439	8,842
Forest	56	98	118	144	157	160	159	162	173	174	183	185
Franklin	1,193	1,944	2,504	3,158	3,604	3,820	4,046	4,208	4,366	4,577	4,758	4,993
Fulton	133	227	294	352	384	402	422	437	444	464	488	530
Greene	381	612	742	926	1,052	1,148	1,247	1,335	1,380	1,421	1,496	1,574
Huntingdon	428	643	824	987	1,091	1,159	1,228	1,288	1,320	1,387	1,490	1,608
Indiana	850	1,341	1,706	2,109	2,405	2,611	2,777	2,916	3,032	3,150	3,312	3,514
Jefferson	342	541	689	846	971	1,036	1,086	1,160	1,193	1,226	1,298	1,372
Juniata	200	377	440	544	585	622	648	679	693	725	763	810
Lackawanna	2,584	4,081	5,328	6,822	7,816	8,378	8,915	9,389	9,848	10,329	10,810	11,326
Lancaster	4,143	6,559	8,144	10,667	12,331	13,091	13,941	14,562	15,092	15,698	16,423	17,327
Lawrence	1,188	1,787	2,175	2,650	2,945	3,074	3,238	3,421	3,521	3,674	3,796	3,961
Lebanon	968	1,628	2,131	2,747	3,197	3,429	3,647	3,853	4,023	4,217	4,343	4,610
Lehigh	4,171	7,834	9,784	11,826	13,172	13,995	14,753	15,399	15,836	16,366	16,961	17,781
Luzerne	3,660	6,113	7,539	9,617	11,010	11,716	12,361	12,902	13,421	14,047	14,613	15,375
Lycoming	1,358	2,062	2,547	3,104	3,464	3,696	4,007	4,218	4,388	4,588	4,784	5,056
McKean	507	793	984	1,214	1,377	1,470	1,536	1,609	1,669	1,740	1,789	1,904
Mercer	1,147	1,886	2,333	2,797	3,088	3,275	3,438	3,628	3,779	3,919	4,115	4,351
Mifflin	414	664	823	978	1,096	1,168	1,261	1,357	1,403	1,462	1,519	1,601
Monroe	1,765	3,010	3,895	5,029	5,681	5,981	6,334	6,645	6,850	7,062	7,444	7,836

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County	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Montgomery	4,342	7,633	9,999	12,799	14,480	15,169	15,906	16,540	17,168	17,884	18,940	20,290
Montour	117	183	257	308	346	378	386	422	446	463	480	518
Northampton	2,256	3,736	4,814	6,053	6,642	6,968	7,337	7,611	7,846	8,084	8,458	9,058
Northumberland	725	1,278	1,779	2,275	2,586	2,774	2,955	3,140	3,259	3,390	3,579	3,762
Perry	200	352	461	627	724	766	807	848	891	921	978	1,039
Philadelphia	24,668	41,586	52,878	67,286	76,380	81,411	86,403	90,524	93,935	98,107	102,481	107,979
Pike	519	828	1,079	1,358	1,521	1,583	1,680	1,758	1,842	1,921	2,087	2,234
Potter	136	242	347	433	481	487	528	562	587	604	648	689
Schuylkill	1,228	1,947	2,507	3,056	3,411	3,617	3,805	4,001	4,181	4,369	4,582	4,800
Snyder	206	357	494	634	704	760	784	800	848	875	911	966
Somerset	737	1,148	1,446	1,769	1,984	2,071	2,204	2,300	2,407	2,507	2,645	2,814
Sullivan	41	62	81	96	107	111	124	131	138	143	152	163
Susquehanna	237	419	590	809	924	997	1,075	1,158	1,187	1,244	1,337	1,387
Tioga	323	538	682	886	1,010	1,093	1,168	1,229	1,247	1,296	1,381	1,482
Union	168	251	318	388	440	452	490	505	536	545	582	637
Venango	461	791	963	1,155	1,268	1,298	1,351	1,409	1,484	1,562	1,643	1,724
Warren	302	476	624	761	852	918	965	1,017	1,057	1,095	1,167	1,218
Washington	1,642	2,379	3,092	3,811	4,286	4,535	4,788	5,000	5,209	5,446	5,755	6,080
Wayne	356	677	904	1,110	1,234	1,293	1,337	1,387	1,415	1,455	1,551	1,664
Westmoreland	2,708	4,102	5,437	6,625	7,328	7,735	8,163	8,522	8,857	9,276	9,912	10,555
Wyoming	135	240	328	439	496	540	569	604	607	641	670	730
York	3,386	4,882	6,471	8,265	9,692	10,451	11,086	11,643	12,078	12,547	13,108	13,754

Table source: PA DHS. Calculated from enrollment and utilization data provided by PA DHS on January 3, 2017 for the purposes of this report.

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8.6 Covered Services under Healthy PA from January to April 2015 and under HealthChoices Expansion after April 2015

The following table compares the coverage limitations of services provided by the three benefit packages under the Medicaid State Plan and the Healthy PA waiver benefit packages in relation to the coverage provided by the adult benefit package under HealthChoices Expansion. In general, the new adult benefit package maintained or increased the coverage of services provided by at least one of the three Healthy PA benefit packages.

Table 29. Summary Service Coverage Limitation Comparison between Benefit Packages Provided by the Healthy PA Demonstration Waiver and HealthChoices Expansion

Coverage of HealthChoices benefit package compared to coverage provided by Healthy PA waiver benefit packages	
Same coverage	**Increase in coverage from at least one of the three packages**
• Primary Care Provider • Physician Services • Certified Registered Nurse Practitioner • Federally Qualified Health Center/Rural Health Clinic • Independent Clinic • Outpatient Hospital Clinic • Podiatrist Services • Radiology • Outpatient Hospital Short Procedure Unit • Outpatient Ambulatory Surgical Center (ASC) • Family Planning Clinic • Inpatient Acute Hospital • Inpatient Drug and Alcohol • Maternity • Crisis • Durable Medical Equipment (DME) • Laboratory	• Chiropractor • Optometrist Services • Dental Services • Non-Emergency Medical Transport (NEMT) • Hospice • Renal Dialysis • Emergency Room • Ambulance • Inpatient Rehab Hospital • Inpatient Psychiatric Hospital • Outpatient Psychiatric Clinic • Mobile Mental Health Treatment • Psychiatric Partial Hospital • Peer Support • Outpatient Drug and Alcohol Treatment and Methadone Maintenance • Clozapine • Targeted Case Management – Other Than Behavioral Health • Targeted Case Management – Behavioral Health Only • Prescription Drugs

Coverage of HealthChoices benefit package compared to coverage provided by Healthy PA waiver benefit packages	
Same coverage	**Increase in coverage from at least one of the three packages**
	• Nutritional Supplements • Skilled Nursing Facility • Home Health Care • ICF/IID and ICF/ORC • Eyeglass Lenses, Frames, and Contact Lenses • Medical Supplies • Therapy (Rehabilitative) • Therapy (Habilitative) • Tobacco Cessation

Table Sources: PA DHS. Benefit Plan Comparison. Retrieved from pa.gov: http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_138044.pdf. PA DHS. Adult Benefit Package. Retrieved from pa.gov: http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_172249.pdf.

The following table compares covered services between the benefit packages in place under Healthy PA from January to April 2015 and the new adult benefit package provided by HealthChoices Expansion after April 2015.

Table 30. Covered Services between the Benefit Packages in place under Healthy PA from January to April 2015 and the New Adult Benefit Package provided by HealthChoices after April 2015

	Healthy PA Waiver			HealthChoices Expansion
Services by Categories	**"Interim" Healthy Package, Current Medicaid Benefit as of Jan. 1, 2015**	**Healthy Plus Package as presented in SPA14-0048**	**PCO Package as presented in SPA 14-0049**	**Adult Benefit package presented in SPA 15-0015, 15-0016**
Category 1: Ambulatory Services				
Primary Care Provider	No limits	No limits	No limits	No limits
Physician's Services	No limits	No limits	No limits	No limits
Certified Registered Nurse Practitioner	No limits	No limits	No limits	No limits
Federally Qualified Health Center/Rural Health Clinic	No limits except for Dental Care Services as described below	No limits except for Dental Care Services as described below	No limits except for Dental Care Services as described below	No limits except for Dental Care services as described below
Independent Clinic	No limits	No limits	No limits	No limits
Outpatient Hospital Clinic	No limits	No limits	No limits	No limits
Podiatrist Services	No limits	No limits	No limits	No limits
Chiropractor Services	No limits	10 visits per calendar year	20 visits per calendar year	No limits

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	Healthy PA Waiver			HealthChoices Expansion
Services by Categories	**"Interim" Healthy Package, Current Medicaid Benefit as of Jan. 1, 2015**	**Healthy Plus Package as presented in SPA14-0048**	**PCO Package as presented in SPA 14-0049**	**Adult Benefit package presented in SPA 15-0015, 15-0016**
Optometrist Services	2 visits (exams) per calendar year	1 visit per calendar year	1 visit per two calendar years	2 visits (exams) per calendar year
Radiology (For example: X-Rays, MRIs, CTs)	No limits	No limits	No limits	No limits
Dental Services	Diagnostic, preventive, restorative, and surgical dental procedures; prosthodontics; and sedation Key Limitations: • Dentures – 1 per lifetime • Exams/prophylaxis – 1 per 180 days • Crowns, Periodontics, and Endodontics: only via approved benefit limit exception	Diagnostic, preventive, restorative, and surgical dental procedures; prosthodontics; and sedation Key Limitations: • Dentures – 1 per lifetime • Exams/prophylaxis – 1 per 180 days • Crowns, Periodontics, and Endodontics: only via approved benefit limit exception	Not covered**	Diagnostic, preventive, restorative, and surgical dental procedures; prosthodontics; and sedation Key Limitations: • Dentures – 1 upper and 1 lower arch (complete or partial) per lifetime; relines (complete or partial) 1 arch, every 2 years • Exams/prophylaxis – 1 per 180 days • Crowns, Periodontics, and Endodontics: via approved benefit limit exception • Panoramic Maxilla or Mandible, single film – 1 per 5 years
Outpatient Hospital	No limits	No limits	No limits	No limits

	Healthy PA Waiver			HealthChoices Expansion
Services by Categories	**"Interim" Healthy Package, Current Medicaid Benefit as of Jan. 1, 2015**	**Healthy Plus Package as presented in SPA14-0048**	**PCO Package as presented in SPA 14-0049**	**Adult Benefit package presented in SPA 15-0015, 15-0016**
Short Procedure Unit (SPU)				
Outpatient Ambulatory Surgical Center (ASC)	No limits	No limits	No limits	No limits
Non-Emergency Medical Transport	Only to and from Medicaid covered services	Only to and from Medicaid covered services	Not covered**	Only to and from Medicaid covered services
Family Planning Clinic	No limits	No limits	No limits	No limits
Hospice Services	No limits, except respite care, which may not exceed a total of 5 days in a 60-day certification period.	No limits, except for respite care, which may not exceed a total of 5 days in a 60-day certification period	No limits; respite care is not provided	No limits, except for respite care, which may not exceed a total of 5 days in a 60-day certification period
Renal Dialysis	Initial training for home dialysis is limited to 24 sessions per patient per calendar year Backup visits to the facility limited to no more than 26 per calendar year	Initial training for home dialysis is limited to 24 sessions per patient per calendar year Backup visits to the facility limited to no more than 75 per calendar year	Not covered**	Initial training for home dialysis is limited to 24 sessions per patient per calendar year Backup visits to the facility limited to no more than 75 per calendar year
Category 2: Emergency Services				
Emergency Room	No limits	No limits	No limits on emergency services	No limits

	Healthy PA Waiver			HealthChoices Expansion
Services by Categories	**"Interim" Healthy Package, Current Medicaid Benefit as of Jan. 1, 2015**	**Healthy Plus Package as presented in SPA14-0048**	**PCO Package as presented in SPA 14-0049**	**Adult Benefit package presented in SPA 15-0015, 15-0016**
			Non-emergency services are not covered	
Ambulance	No limits	No limits	No limits on emergency services Non-emergency services are not covered	No limits
Category 3: Hospitalization				
Inpatient Acute Hospital	No limits	No limits	No limits	No limits
Inpatient Rehab Hospital	1 admit per calendar year	No limits	No limits	No limits
Inpatient Psychiatric Hospital	30 days per calendar year	No limits	No limits	No limits
Inpatient Drug & Alcohol	No limits	No limits	No limits	No limits
Category 4: Maternity and Newborn				
Maternity – Physician, Certified Nurse Midwives, Birth Centers	No limits	No limits	No limits	No limits
Category 5: Mental Health and Substance Use Disorder (Behavioral Health)				

	Healthy PA Waiver			HealthChoices Expansion
Services by Categories	**"Interim" Healthy Package, Current Medicaid Benefit as of Jan. 1, 2015**	**Healthy Plus Package as presented in SPA14-0048**	**PCO Package as presented in SPA 14-0049**	**Adult Benefit package presented in SPA 15-0015, 15-0016**
Outpatient Psychiatric Clinic	5 hours or 10 one-half hour sessions of psychotherapy per recipient per 30 consecutive days	No limits	No limits	No limits
Mobile Mental Health Treatment	5 hours or 10 one-half hour sessions of psychotherapy per recipient per 30 consecutive days	No limits	Not covered**	No limits
Psychiatric Partial Hospital	540 hours per calendar year	No limits	No limits	No limits
Peer Support	4 hours per day/900 hours per year	No limits	Not covered**	No limits
Crisis Intervention Services	No limits	No limits	No limits	No limits
Outpatient Drug and Alcohol Treatment and Methadone Maintenance Clinic Services	Opiate Detox: 42 visits per 365 days Chemotherapy/Drug-free visits: 3 visits per 30 days Methadone Maintenance: 1 visit per day/7 visits per week	No limits	No limits	No limits
Clozapine	Limited to persons with Schizophrenia 1 per week	No limits	No limits	No limits

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	Healthy PA Waiver			HealthChoices Expansion
Services by Categories	**"Interim" Healthy Package, Current Medicaid Benefit as of Jan. 1, 2015**	**Healthy Plus Package as presented in SPA14-0048**	**PCO Package as presented in SPA 14-0049**	**Adult Benefit package presented in SPA 15-0015, 15-0016**
Targeted Case Management – Other than Behavioral Health	Limited to individuals identified in the target group (No limits)	Limited to individuals identified in the target group (No limits)	Not covered **	Limited to individuals identified in the target group (No limits)
Targeted Case Management – Behavioral Health Only	Limited to individuals with serious mental illness (SMI) only (No limits)	Limited to individuals with serious mental illness (SMI) only (No limits)	Not covered**	Limited to individuals with serious mental illness (SMI) only (No limits)
Category 6: Prescription Drugs				
Prescription Drugs	6 per month	No limits	No limits	No limits
Nutritional Supplements	No limits	No limits	Not covered**	No limits
Category 7: Rehabilitation and Habilitation Services and Devices				
Skilled Nursing Facility	365 days per calendar year	365 days per calendar year	120 days per calendar year	365 days per calendar year
Home Health Care	Unlimited for first 28 days; limited to 15 days every month thereafter	Unlimited for first 28 days; limited to 15 days every other month thereafter	60 visits per year	Unlimited for first 28 days for combined services of Home Health Aide, Home Health Therapies, and Intermittent or Part-time Nursing Services by home health agency; limited to 15 days every month thereafter
ICF/IID and ICF/ORC	Requires an institutional level of care (No limits)	Requires an institutional level of care (No limits)	Not covered**	Requires an institutional level of care (No limits)

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	Healthy PA Waiver			HealthChoices Expansion
Services by Categories	**"Interim" Healthy Package, Current Medicaid Benefit as of Jan. 1, 2015**	**Healthy Plus Package as presented in SPA14-0048**	**PCO Package as presented in SPA 14-0049**	**Adult Benefit package presented in SPA 15-0015, 15-0016**
Durable Medical Equipment	No limits	No limits	No limits	No limits
Eyeglass Lenses	Limited to individuals with aphakia 4 lenses per calendar year	Limited to individuals with aphakia 4 lenses per calendar year	Not covered**	Limited to individuals with aphakia 4 lenses per calendar year
Eyeglass Frames	Limited to individuals with aphakia 2 frames per calendar year	Limited to individuals with aphakia 2 frames per calendar year	Not covered**	Limited to individuals with aphakia 2 frames per calendar year
Contact Lenses	Limited to individuals with aphakia 4 lenses per calendar year	Limited to individuals with aphakia 4 lenses per calendar year	Not covered**	Limited to individuals with aphakia 4 lenses per calendar year
Medical Supplies	No limits	$2,500 per calendar year No limits for diabetic supplies provided by pharmacies	Not covered ** Except for diabetic supplies provided by pharmacies, no limits	No limits
Therapy (Physical, Occupational, Speech) – Rehabilitative	Only when provided by a hospital, outpatient clinic, or home health provider	30 visits per calendar year combined for Physical and Occupational Therapy 30 visits per calendar year for Speech Therapy	30 visits per calendar year combined for Physical and Occupational Therapy 30 visits per calendar year for Speech Therapy	Only when provided by a hospital, outpatient clinic, or home health provider
Therapy (Physical, Occupational, Speech) -- Habilitative	Only when provided by a hospital, outpatient clinic, or home health provider	30 visits per calendar year combined for Physical and Occupational Therapy 30 visits per calendar year for Speech Therapy	30 visits per calendar year combined for Physical and Occupational Therapy 30 visits per calendar year for Speech Therapy	Only when provided by a hospital, outpatient clinic, or home health provider
Category 8: Laboratory Services				

	Healthy PA Waiver			HealthChoices Expansion
Services by Categories	**"Interim" Healthy Package, Current Medicaid Benefit as of Jan. 1, 2015**	**Healthy Plus Package as presented in SPA14-0048**	**PCO Package as presented in SPA 14-0049**	**Adult Benefit package presented in SPA 15-0015, 15-0016**
Laboratory	No limits	No limits	No limits	No limits
Category 9: Preventative / Wellness Services and Chronic Care				
Tobacco Cessation*	70 visits per calendar year	70 visits per calendar year	As recommended by the Preventive Services Task Force	70 visits per calendar year

All units of service, age, gender, diagnosis, and other procedure code-related limits still apply as indicated on the Medicaid Fee Schedule.

** Optional for PCO, not an Essential Health Benefit.

* Tobacco cessation is one of the preventative services as recommended by the US Preventative Services Task Force. The MCOs can provide a full listing of preventative services beyond tobacco cessation.

Table Sources: PA DHS. Benefit Plan Comparison. Retrieved from pa.gov: http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_138044.pdf. PA DHS. Adult Benefit Package. Retrieved from pa.gov: http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_172249.pdf.

8.7 Economic Impacts

The following table provides projections of the impact of newly eligible Medicaid expansion on economic outputs for North American Industry Classification System (NAICS) sectors in CY 2015, based on the IMPLAN economic modeling software. The health and social services sector saw the largest, modeled change in outputs at $1 billion.

Table 31. Projected Impact of Medicaid Expansion on Outputs by Sector in CY 2015

Sector	Total Effects on Outputs	Percent of Total Outputs
Health & Social Services	$1,013,751,946	46%
Retail Trade	$307,434,555	14%
Real Estate & Rental	$198,354,368	9%
Finance & Insurance	$146,793,600	7%
Professional, Scientific, & Technical Services	$79,910,886	4%
Information	$63,581,267	3%
Manufacturing	$60,124,985	3%
Wholesale Trade	$54,041,184	2%
Administrative & Waste Services	$51,494,433	2%
Other Services	$41,423,958	2%
Accommodation & Food Services	$39,619,817	2%
Transportation & Warehousing	$38,164,699	2%
Management of Companies	$29,265,367	1%
Utilities	$28,018,891	1%
Educational Services	$16,795,322	1%
Construction	$15,494,561	1%
Govt. enterprises, incl. Postal Service	$15,160,298	1%
Arts- Entertainment & Recreation	$15,058,136	1%
Mining	$4,638,509	0%
Ag, Forestry, Fish & Hunting	$2,951,473	0%
Government Education	$0	0%
Government non-Education, Military & non-NAICS	$0	0%
Total	**$2,222,078,256**	100%

Totals are approximate due to rounding.

*Table Source: IMPLAN economic impact analysis**.** PA DHS provided input data for IMPLAN modeling, containing Medicaid expenditures for health care services in CY 2015 attributable to newly eligible Medicaid expansion enrollees. Provider payments amounts were adjusted to reflect the costs associated with the former enrollees in* **the GA** *Medical Assistance program in CY 2014 who migrated into Medicaid expansion in 2015.*

The following table provides projections of the impact of newly eligible Medicaid expansion on employment counts for NAICS sectors in CY 2015, based on the IMPLAN economic modeling software. Similar to the previous table, the health and social services sector saw the largest, modeled change in full-time equivalent (FTE) employment counts, adding over 7,400 projected jobs.

Table 32. Projected Impact of Medicaid Expansion on FTE Employment Counts by Sector in CY 2015

Sector	Total Effect on Full-Time Equivalent (FTE) Employment	Percent of Total FTE Employment Count
Health & Social Services	7,434	48%
Retail Trade	3,339	22%
Administrative & Waste Services	692	4%
Finance & Insurance	641	4%
Accommodation & Food Services	568	4%
Professional, Scientific, & Technical Services	550	4%
Other Services	465	3%
Real Estate & Rental	439	3%
Transportation & Warehousing	271	2%
Wholesale Trade	208	1%
Educational Services	180	1%
Arts- Entertainment & Recreation	154	1%
Information	117	1%
Manufacturing	108	1%
Management of Companies	106	1%
Construction	88	1%
Government Enterprises, incl. Postal Service	86	1%
Agriculture, Forestry, Fish & Hunting	24	0%
Utilities	23	0%
Mining	11	0%
Government Education	0	0%
Govt. non-Education, Military & non-NAICS	0	0%
Total	**15,505**	**100%**

Totals are approximate due to rounding.

*Table Source: IMPLAN economic impact analysis**.** PA DHS provided input data for IMPLAN modeling, containing Medicaid expenditures for health care services in CY 2015 attributable to newly eligible Medicaid expansion enrollees. Provider payments amounts were adjusted to reflect the costs associated with the former enrollees in* **the GA** *Medical Assistance program in CY 2014 who migrated into Medicaid expansion in 2015.*

The following table provides projections of the impact of newly eligible Medicaid expansion on Labor Income for NAICS sectors in CY 2015, based on the IMPLAN economic modeling software. Similar to the previous table, the health and social services sector saw the largest addition of labor income, totaling over $550 million.

Table 33. Projected Impact of Medicaid Expansion on Labor Income in CY 2015

Sector	Labor Income	Percent of Total Labor Income
Health & Social Services	$550,273,340	55%
Retail Trade	$159,102,039	16%
Finance & Insurance	$49,935,981	5%
Professional, Scientific, & Technical Services	$46,036,646	5%
Administrative & Waste Services	$28,651,360	3%
Other Services	$22,498,662	2%
Information	$19,951,314	2%
Wholesale Trade	$19,647,485	2%
Accommodation & Food Services	$15,827,340	2%
Management of Companies	$15,785,821	2%
Transportation & Warehousing	$14,948,853	1%
Real Estate & Rental	$13,197,598	1%
Educational Services	$9,632,189	1%
Government Enterprises, incl. Postal Service	$8,391,154	1%
Manufacturing	$8,225,638	1%
Construction	$5,521,364	1%
Arts- Entertainment & Recreation	$4,802,865	0%
Utilities	$3,543,857	0%
Mining	$1,108,040	0%
Agriculture, Forestry, Fish & Hunting	$647,717	0%
Government Education	$0	0%
Govt. non-Education, Military & non-NAICS	$0	0%
Total	**$997,729,262**	**100%**

Totals are approximate due to rounding.

*Table Source: IMPLAN economic impact analysis. PA DHS provided input data for IMPLAN modeling, containing Medicaid expenditures for health care services in CY 2015 attributable to newly eligible Medicaid expansion enrollees. Provider payments amounts were adjusted to reflect the costs associated with the former enrollees in **the GA** Medical Assistance program in CY 2014 who migrated into Medicaid expansion in 2015.*

The following table provides projections of the impact of newly eligible Medicaid expansion on indirect business taxes for NAICS sectors in CY 2015, based on the IMPLAN economic modeling software. The retail trade sector produced nearly one-third of all indirect business taxes paid to the state.

Table 34. Projected Impact of Medicaid Expansion on Indirect Business Taxes in CY 2015

Sector	Indirect Business Taxes	Percent of the Total Indirect Business Taxes
Retail Trade	$21,267,888	31%
Real Estate & Rental	$16,711,063	24%
Wholesale Trade	$7,206,807	11%
Health & Social Services	$4,467,937	7%
Finance & Insurance	$4,279,055	6%
Utilities	$2,800,941	4%
Information	$2,212,019	3%
Accommodation & Food Services	$2,120,432	3%
Other Services	$2,086,547	3%
Professional, Scientific, & Technical Services	$1,807,296	3%
Arts - Entertainment & Recreation	$1,651,217	2%
Management of Companies	$853,525	1%
Transportation & Warehousing	$599,874	1%
Administrative & Waste Services	$559,676	1%
Manufacturing	$476,452	1%
Educational Services	$280,161	0%
Mining	$182,860	0%
Construction	$53,931	0%
Ag, Forestry, Fish & Hunting	$34,143	0%
Government Education	$0	0%
Government Non-education, Military & Non-NAICS	$0	0%
Govt. Enterprises, incl. Postal Service	- $1,064,436	-2%
Total	**$68,587,389**	**100%**

Totals are approximate due to rounding.

*Table Source: IMPLAN economic impact analysis. PA DHS provided input data for IMPLAN modeling, containing Medicaid expenditures for health care services in CY 2015 attributable to newly eligible Medicaid expansion enrollees. Provider payments amounts were adjusted to reflect the costs associated with the former enrollees in **the GA** Medical Assistance program in CY 2014 who migrated into Medicaid expansion in 2015.*

8.8 Provider Types Serving Medicaid Expansion Enrollees between April 1, 2015 and March 31, 2016

The following maps break down various provider types by county that performed paid Medicaid services to Medicaid expansion enrollees between April 1, 2015 and March 31, 2016.

Figure 31. Inpatient Facilities that Provided Paid Medicaid Services to Medicaid Expansion Enrollees between April 1, 2015 and March 31, 2016 by County

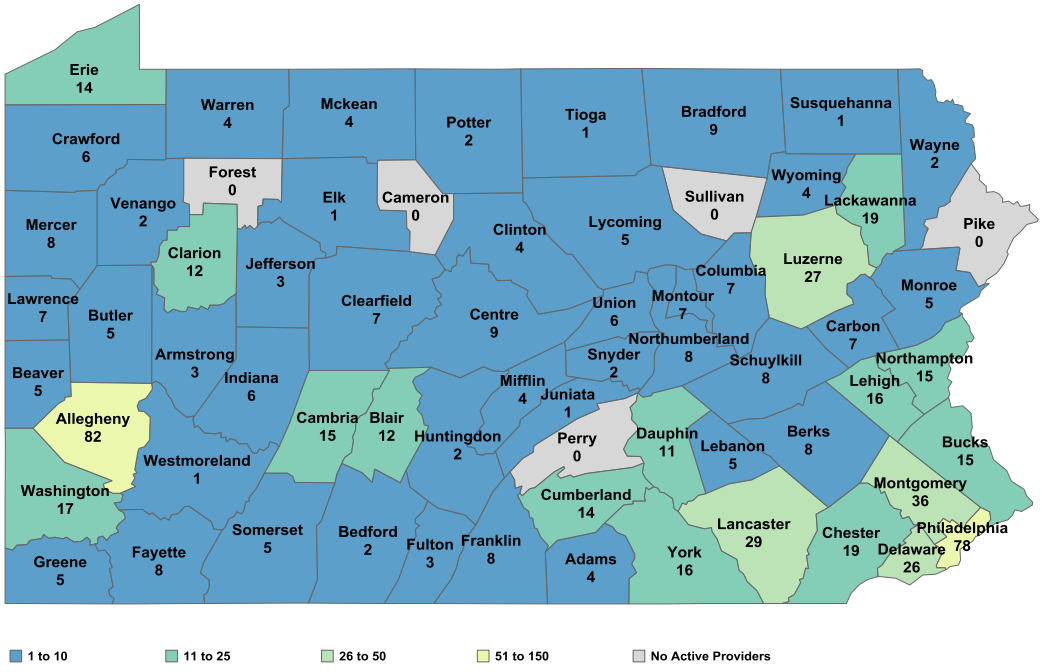


Figure 32. Nurse Practitioner Providers that Provided Paid Medicaid Services to Medicaid Expansion Enrollees between April 1, 2015 and March 31, 2016 by County

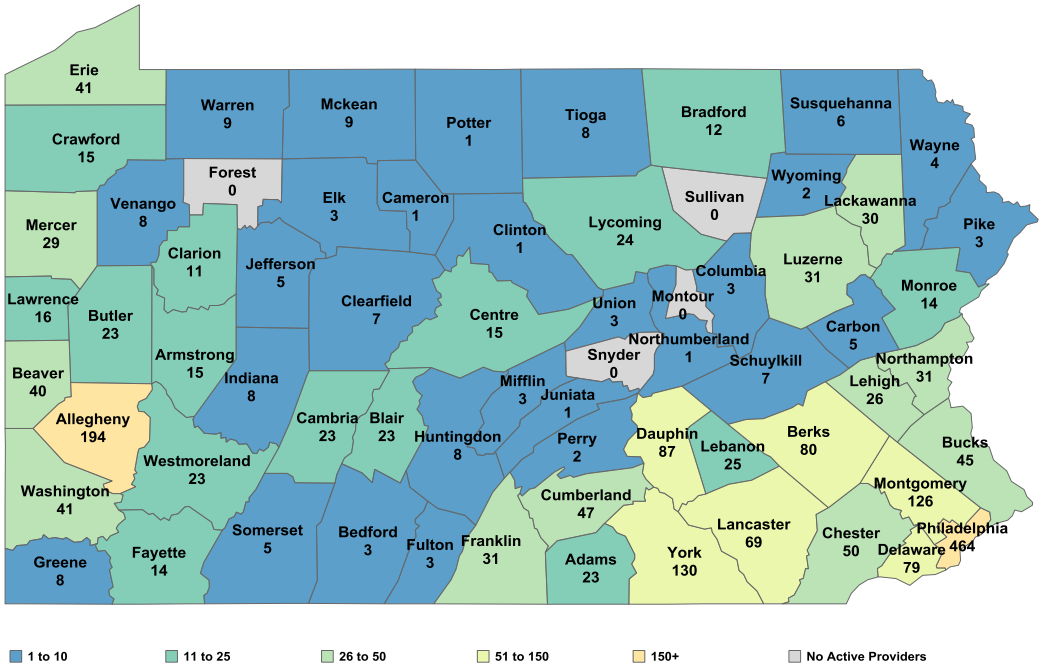


Figure 33. Dentist Providers that Provided Paid Medicaid Services to Medicaid Expansion Enrollees between April 1, 2015 and March 31, 2016 by County

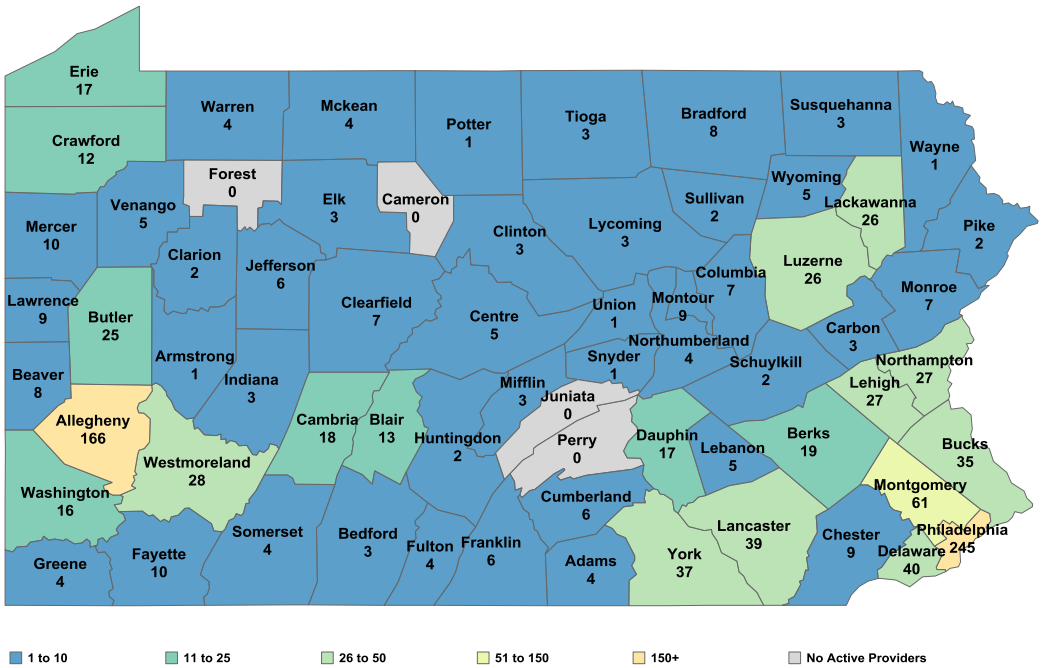


Figure 34. Mental Health/Substance Use Disorder Providers that Provided Paid Medicaid Services to Medicaid Expansion Enrollees between April 1, 2015 and March 31, 2016 by County

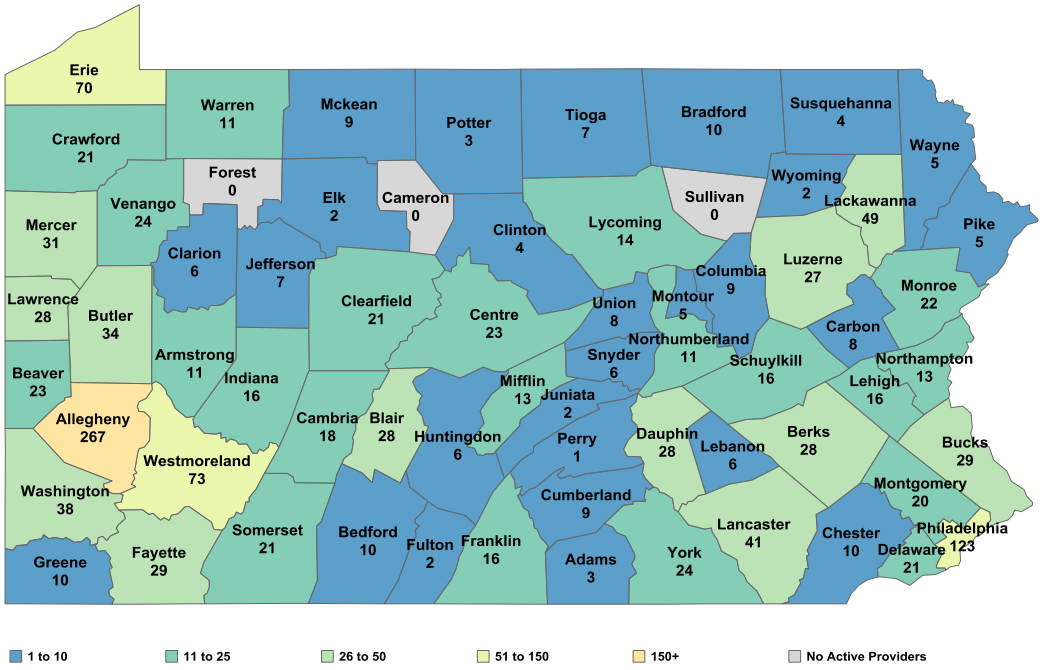
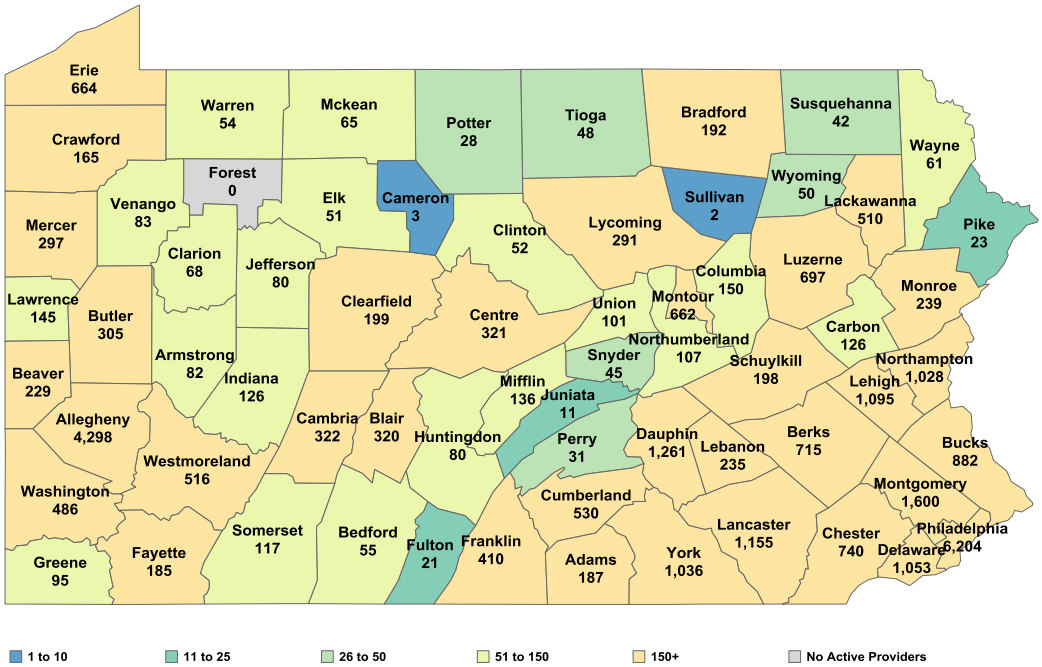


Figure 35. Physician Providers that Provided Paid Medicaid Services to Medicaid Expansion Enrollees between April 1, 2015 and March 31, 2016 by County



Source for preceding figures: PA DHS. Identified performing providers from enrollment and utilization data provided by DHS on January 3, 2017 for the purposes of this report.

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8.9 Uncompensated Care by General Acute Care Hospital

On an annual basis, the Pennsylvania Health Care Cost Containment Council (PHC4) produces a series of reports that measure the financial health of Pennsylvania's hospitals and ambulatory surgery centers. The following table breaks down uncompensated care by general acute care hospital as reported by the PHC4 for that particular hospital's fiscal year 2014 and 2015. The data included is based on each facility's fiscal year that ended either during 2015 or 2014. The fiscal year for the majority of hospitals is on a calendar year basis ending on December 31. For those hospitals that do not utilize a calendar year basis, the fiscal year typically ends on June 30 annually. More information on PHC4's Financial Analysis Annual Reports is available at http://www.phc4.org/reports/fin/.

Table 35. Uncompensated Care by General Acute Care Hospital during Facility's Fiscal Year 2014 and 2015

General Acute Care (GAC) Hospital	Net Patient Revenue (Thousands) FY15	Percent of Uncompensated Care FY15	Net Patient Revenue (Thousands) FY14	Percent of Uncompensated Care FY14	Difference in Net Patient Revenue	Difference in Uncompensated Care
Statewide GAC Average	**$236,530**	**2.42%**	**$224,149**	**2.78%**	**$12,381**	**-0.36%**
ACMH	$94,034	1.35%	$93,016	2.06%	$1,018	-0.71%
Advanced Surgical	$17,544	0.28%	$14,650	0.35%	$2,894	-0.07%
Allegheny General	$678,323	1.92%	$308,085	1.70%	$370,238	+0.22%
Allegheny Valley	$99,109	3.79%	$50,062	-2.58%	$49,047	+6.37%
Butler Memorial	$231,963	1.54%	$216,685	1.56%	$15,278	-0.02%
Canonsburg	$45,194	3.70%	$22,824	-2.97%	$22,370	+6.67%
Children's Hospital UPMC	$523,360	2.40%	$480,755	2.57%	$42,605	-0.17%
Excela Health Westmoreland	$225,976	2.42%	$212,120	2.63%	$13,856	-0.21%
Forbes	$195,010	2.24%	$93,080	1.93%	$101,930	+0.31%
Frick	$43,690	3.72%	$45,073	3.68%	-$1,383	+0.04%
Heritage Valley Beaver	$219,081	3.01%	$214,328	2.67%	$4,753	+0.34%
Heritage Valley Sewickley	$119,022	2.93%	$118,420	2.86%	$602	+0.07%
Highlands	$23,694	4.65%	$22,989	4.72%	$705	-0.07%
Jefferson	$218,669	3.19%	$107,082	2.47%	$111,587	+0.72%
Latrobe Area	$121,851	2.38%	$117,434	2.68%	$4,417	-0.30%

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General Acute Care (GAC) Hospital	Net Patient Revenue (Thousands) FY15	Percent of Uncompensated Care FY15	Net Patient Revenue (Thousands) FY14	Percent of Uncompensated Care FY14	Difference in Net Patient Revenue	Difference in Uncompensated Care
Magee Womens UPMC	$836,663	1.74%	$509,978	2.37%	$326,685	-0.63%
Monongahela Valley	$130,947	1.08%	$125,265	2.70%	$5,682	-1.62%
Ohio Valley General	$55,308	2.37%	$50,236	2.25%	$5,072	+0.12%
Southwest Regional	$13,925	3.34%	$28,687	4.73%	-$14,762	-1.39%
St Clair Memorial	$260,400	2.36%	$239,506	1.00%	$20,894	+1.36%
Uniontown	$119,938	3.98%	$115,958	4.50%	$3,980	-0.52%
UPMC East	$125,872	3.04%	$112,350	2.82%	$13,522	+0.22%
UPMC McKeesport	$133,266	5.39%	$139,324	5.42%	-$6,058	-0.03%
UPMC Mercy	$355,864	3.99%	$339,822	4.93%	$16,042	-0.94%
UPMC Passavant	$353,508	1.56%	$378,909	1.83%	-$25,401	-0.27%
UPMC Presby Shadyside	$1,757,684	1.74%	$2,077,925	2.11%	-$320,241	-0.37%
UPMC St Margaret	$224,041	1.80%	$225,970	1.98%	-$1,929	-0.18%
Washington	$224,191	4.58%	$223,291	3.69%	$900	+0.89%
West Penn	$316,354	0.51%	$104,254	0.94%	$212,100	-0.43%
Bradford Regional	$67,479	2.23%	$66,797	2.21%	$682	+0.02%
Charles Cole Memorial	$74,480	2.87%	$73,145	3.58%	$1,335	-0.71%
Clarion	$51,928	2.35%	$46,810	4.09%	$5,118	-1.74%
Corry Memorial	$18,409	3.75%	$17,872	4.76%	$537	-1.01%
Edgewood Surgical	$9,149	0.67%	$8,365	0.62%	$784	+0.05%
Ellwood City	$25,205	2.41%	$28,290	1.79%	-$3,085	+0.62%
Grove City	$42,204	2.25%	$42,091	2.42%	$113	-0.17%
Jameson Memorial	$102,852	3.27%	$105,357	4.18%	-$2,505	-0.91%
Kane Community	$20,235	2.71%	$18,867	2.67%	$1,368	+0.04%
Meadville	$157,460	2.55%	$149,771	2.10%	$7,689	+0.45%
Millcreek Community	$53,050	3.08%	$44,681	3.02%	$8,369	+0.06%
Penn Highlands Brookville	$25,101	2.39%	$24,001	3.52%	$1,100	-1.13%
Penn Highlands Clearfield	$42,572	2.97%	$46,218	4.01%	-$3,646	-1.04%
Penn Highlands DuBois	$249,841	1.86%	$225,494	1.95%	$24,347	-0.09%

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Penn Highlands Elk	$58,216	2.73%	$66,832	3.03%	-$8,616	-0.30%
Punxsutawney Area	$32,921	2.03%	$29,372	4.26%	$3,549	-2.23%
Saint Vincent	$243,663	2.01%	$235,600	2.09%	$8,063	-0.08%
Sharon Regional	$102,635	1.66%	$35,292	1.04%	$67,343	+0.62%
Titusville Area	$21,667	5.91%	$22,441	3.50%	-$774	+2.41%
UPMC Hamot	$360,251	3.02%	$342,912	3.93%	$17,339	-0.91%
UPMC Horizon	$159,095	2.92%	$147,412	3.69%	$11,683	-0.77%
UPMC Northwest	$106,375	3.56%	$100,138	4.75%	$6,237	-1.19%
Warren General	$67,385	2.41%	$65,939	2.01%	$1,446	+0.40%
Conemaugh Memorial	$385,954	1.54%	$360,341	2.69%	$25,613	-1.15%
Conemaugh Meyersdale	$13,754	3.33%	$13,168	5.53%	$586	-2.20%
Conemaugh Miners	$15,967	2.83%	$15,694	4.08%	$273	-1.25%
Indiana Regional	$135,621	3.20%	$132,939	3.49%	$2,682	-0.29%
Nason	$13,644	2.09%	$30,994	2.94%	-$17,350	-0.85%
Somerset	$62,810	1.34%	$61,943	2.23%	$867	-0.89%
Tyrone	$20,466	3.72%	$20,985	4.28%	-$519	-0.56%
UPMC Altoona	$357,535	3.03%	$342,596	3.52%	$14,939	-0.49%
UPMC Bedford	$58,509	3.40%	$51,096	3.62%	$7,413	-0.22%
Windber	$36,664	2.15%	$36,329	2.42%	$335	-0.27%
Berwick	$60,643	1.91%	$61,033	1.51%	-$390	+0.40%
Bucktail	$5,392	3.22%	$4,866	5.39%	$526	-2.17%
Evangelical Community	$163,502	2.79%	$152,134	3.09%	$11,368	-0.30%
Geisinger Bloomsburg	$31,665	3.57%	$28,998	3.47%	$2,667	+0.10%
Geisinger Danville	$1,013,933	1.74%	$949,652	1.68%	$64,281	+0.06%
Geisinger Lewistown	$95,748	3.63%	$86,565	4.20%	$9,183	-0.57%
Jersey Shore	$25,487	4.03%	$24,461	5.17%	$1,026	-1.14%
Lock Haven	$28,352	2.16%	$30,918	2.04%	-$2,566	+0.12%
Mount Nittany	$313,921	1.86%	$290,576	1.90%	$23,345	-0.04%

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Muncy Valley	$44,974	3.65%	$44,847	3.13%	$127	+0.52%
Soldiers & Sailors	$55,480	3.49%	$53,134	3.96%	$2,346	-0.47%
Sunbury Community	$19,069	2.04%	$21,085	1.90%	-$2,016	+0.14%
Williamsport Regional	$261,458	2.57%	$244,085	3.14%	$17,373	-0.57%
Carlisle Regional	$121,412	2.78%	$130,850	2.76%	-$9,438	+0.02%
Chambersburg	$291,310	4.06%	$280,412	4.56%	$10,898	-0.50%
Ephrata Community	$180,711	2.31%	$176,276	3.88%	$4,435	-1.57%
Fulton County	$40,274	3.27%	$38,633	3.57%	$1,641	-0.30%
Gettysburg	$159,645	4.81%	$135,777	6.22%	$23,868	-1.41%
Good Samaritan Lebanon	$162,435	3.85%	$154,763	3.75%	$7,672	+0.10%
Hanover	$157,520	2.85%	$143,055	3.01%	$14,465	-0.16%
Heart of Lancaster	$60,704	1.56%	$63,207	2.98%	-$2,503	-1.42%
Holy Spirit	$288,604	1.71%	$304,382	2.38%	-$15,778	-0.67%
J C Blair Memorial	$38,950	2.96%	$34,348	3.41%	$4,602	-0.45%
Lancaster General	$875,764	3.27%	$819,657	3.39%	$56,107	-0.12%
Lancaster Regional	$109,877	1.68%	$111,845	2.62%	-$1,968	-0.94%
Memorial York	$76,858	4.69%	$85,815	4.30%	-$8,957	+0.39%
Milton S Hershey	$1,261,664	2.36%	$1,158,094	2.66%	$103,570	-0.30%
OSS Orthopedic	$81,529	0.74%	$79,111	0.53%	$2,418	+0.21%
Pinnacle Health	$809,936	4.35%	$738,187	4.82%	$71,749	-0.47%
Waynesboro	$61,952	5.62%	$57,337	6.29%	$4,615	-0.67%
Wellspan Surgery & Rehab	$52,362	2.34%	$43,464	3.55%	$8,898	-1.21%
York	$911,023	3.47%	$834,038	4.18%	$76,985	-0.71%
Barnes-Kasson County	$18,197	5.64%	$19,607	5.80%	-$1,410	-0.16%
Endless Mountains	$19,419	3.81%	$16,279	5.02%	$3,140	-1.21%
Geisinger Community	$188,260	2.49%	$175,404	2.76%	$12,856	-0.27%
Geisinger Wyoming Valley	$445,376	2.71%	$451,939	2.47%	-$6,563	+0.24%
Guthrie Towanda Memorial	$32,460	4.01%	$31,255	2.47%	$1,205	+1.54%

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Lehigh Valley Hazleton	$109,154	3.86%	$51,253	4.28%	$57,901	-0.42%
Mid-Valley	$4,582	7.82%	$9,138	5.15%	-$4,556	+2.67%
Moses Taylor	$122,854	2.67%	$118,004	3.79%	$4,850	-1.12%
Pocono	$258,115	4.34%	$233,834	4.49%	$24,281	-0.15%
Regional Scranton	$141,503	2.10%	$141,175	2.81%	$328	-0.71%
Robert Packer	$275,703	3.24%	$259,231	3.72%	$16,472	-0.48%
Troy Community	$19,897	4.91%	$16,134	5.54%	$3,763	-0.63%
Tyler Memorial	$17,188	1.35%	$18,717	2.84%	-$1,529	-1.49%
Wayne Memorial	$77,202	3.68%	$69,850	4.52%	$7,352	-0.84%
Wilkes-Barre General	$263,599	2.79%	$262,203	2.50%	$1,396	+0.29%
Coordinated Health Ortho	$30,513	0.60%	$30,545	0.27%	-$32	+0.33%
Easton	$171,282	1.40%	$180,754	1.26%	-$9,472	+0.14%
Gnaden Huetten Memorial	$57,197	2.99%	$53,886	3.29%	$3,311	-0.30%
Lehigh Valley Allentown	$1,193,686	1.03%	$1,066,387	3.01%	$127,299	-1.98%
Lehigh Valley Muhlenberg	$224,723	1.87%	$217,050	3.73%	$7,673	-1.86%
Palmerton	$29,266	3.10%	$28,395	3.08%	$871	+0.02%
Reading	$769,852	2.91%	$751,234	2.17%	$18,618	+0.74%
Sacred Heart Allentown	$94,448	1.59%	$95,996	1.62%	-$1,548	-0.03%
Schuylkill East Norwegian	$51,199	1.93%	$49,652	3.17%	$1,547	-1.24%
Schuylkill South Jackson	$79,398	3.22%	$84,153	4.18%	-$4,755	-0.96%
St Joseph Reading	$200,534	2.46%	$193,304	2.57%	$7,230	-0.11%
St Luke's Anderson	$155,906	1.90%	$140,523	2.59%	$15,383	-0.69%
St Luke's Bethlehem	$602,782	2.13%	$563,413	3.16%	$39,369	-1.03%
St Luke's Miners	$52,526	3.28%	$48,253	4.47%	$4,273	-1.19%
Surgical Inst Reading	$23,986	0.29%	$22,301	0.14%	$1,685	+0.15%
Surgical Spec Coordinated	$101,788	0.84%	$97,645	0.07%	$4,143	+0.77%
Abington Memorial	$597,616	2.26%	$591,234	1.85%	$6,382	+0.41%
Barix Clinics PA	$5,596	1.48%	$5,057	2.57%	$539	-1.09%

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Brandywine	$136,451	2.19%	$122,216	1.88%	$14,235	+0.31%
Chester County	$268,610	2.12%	$232,694	2.88%	$35,916	-0.76%
Crozer Chester	$464,910	2.22%	$468,034	3.24%	-$3,124	-1.02%
Delaware County Memorial	$149,917	3.18%	$156,726	3.98%	-$6,809	-0.80%
Doylestown	$228,547	0.66%	$217,444	0.57%	$11,103	+0.09%
Einstein Montgomery	$182,004	2.09%	$167,392	2.00%	$14,612	+0.09%
Grand View	$180,215	2.01%	$168,829	2.56%	$11,386	-0.55%
Holy Redeemer	$181,286	0.79%	$171,573	1.02%	$9,713	-0.23%
Jennersville Regional	$44,957	2.00%	$43,388	2.35%	$1,569	-0.35%
Lansdale	$79,631	1.87%	$78,172	1.58%	$1,459	+0.29%
Lower Bucks	$70,525	6.10%	$75,937	7.41%	-$5,412	-1.31%
Main Line Bryn Mawr	$316,305	1.61%	$306,142	1.48%	$10,163	+0.13%
Main Line Lankenau	$436,599	1.89%	$394,988	1.21%	$41,611	+0.68%
Main Line Paoli	$295,581	2.15%	$283,965	2.54%	$11,616	-0.39%
Mercy Fitzgerald	$166,422	2.84%	$166,371	3.66%	$51	-0.82%
Mercy Suburban	$97,696	2.24%	$92,096	3.39%	$5,600	-1.15%
Phoenixville	$150,010	1.57%	$148,038	1.37%	$1,972	+0.20%
Physicians Care	$25,476	0.62%	$20,025	0.39%	$5,451	+0.23%
Pottstown Memorial	$157,145	1.89%	$171,789	1.56%	-$14,644	+0.33%
Riddle Memorial	$171,105	1.62%	$161,149	1.99%	$9,956	-0.37%
Rothman Ortho Specialty	$38,418	0.06%	$42,456	0.55%	-$4,038	-0.49%
St Luke's Quakertown	$55,667	2.29%	$56,352	3.82%	-$685	-1.53%
St Mary MC	$428,640	2.19%	$426,191	2.82%	$2,449	-0.63%
Albert Einstein	$561,523	3.51%	$538,157	4.32%	$23,366	-0.81%
Aria Health	$419,292	4.26%	$379,784	4.38%	$39,508	-0.12%
Chestnut Hill	$103,585	1.67%	$101,971	1.41%	$1,614	+0.26%
Children's Hospital Phila.	$1,600,820	2.09%	$1,503,365	2.90%	$97,455	-0.81%
Eastern Regional	$387,164	9.25%	$459,498	9.71%	-$72,334	-0.46%

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Hahnemann University	$427,181	0.83%	$384,907	0.96%	$42,274	-0.13%
Hospital Fox Chase Cancer	$292,288	0.40%	$247,289	0.56%	$44,999	-0.16%
Hospital University PA	$2,350,197	1.31%	$2,241,435	1.63%	$108,762	-0.32%
Jeanes	$136,807	2.47%	$137,490	3.04%	-$683	-0.57%
Mercy Philadelphia	$133,460	5.62%	$127,989	5.95%	$5,471	-0.33%
Nazareth	$143,524	3.84%	$140,573	4.70%	$2,951	-0.86%
Penn Presbyterian	$598,511	1.90%	$513,120	2.02%	$85,391	-0.12%
Pennsylvania	$523,538	2.11%	$477,627	2.52%	$45,911	-0.41%
Roxborough Memorial	$60,811	1.58%	$58,559	3.81%	$2,252	-2.23%
Shriners Children Philadelphia	$11,762	15.07%	$13,624	17.41%	-$1,862	-2.34%
St Christopher's Children	$317,251	1.16%	$313,357	0.96%	$3,894	+0.20%
St Joseph's Philadelphia	$100,282	12.54%	$97,121	11.87%	$3,161	+0.67%
Temple University	$916,220	2.78%	$856,197	3.64%	$60,023	-0.86%
Thomas Jefferson University	$1,456,406	1.87%	$1,421,099	2.06%	$35,307	-0.19%
Wills Eye	$20,943	0.61%	$15,257	0.49%	$5,686	+0.12%

Table Sources: PHC4 Financial Analysis 2015. An Annual Report on the Financial Health of Pennsylvania Hospitals, Volume 1: General Acute Care Hospitals. Retrieved from phc4.org: http://www.phc4.org/reports/fin/15/.

PHC4 Financial Analysis 2014. An Annual Report on the Financial Health of Pennsylvania Hospitals, Volume 1: General Acute Care Hospitals. Retrieved from phc4.org http://www.phc4.org/reports/fin/14/docs/fin2014report_volumeone.pdf.