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Health Care Reform and Possible Implications for Ohio's Medicaid Program

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By John R. Corlett

Passage of health care reform legislation would represent a major achievement and result in millions of uninsured Americans and hundreds of thousands of uninsured Ohioans obtaining health care coverage. Families USA estimated that the Senate legislation would result in 866,000 Ohioans gaining health care coverage by 2019. Alternately, they estimate that 229,000 Ohioans will lose health care coverage without passage of the health care reform legislation.[1] These estimates are lower than the House legislation which Families USA estimated would result in 991,000 Ohioans gaining health care coverage by 2019.[2] The Obama administration has also argued that 1.8 million seniors in Ohio would receive free preventive services, and that 325,000 seniors would see their brand-name drug costs in the Medicare Part D "doughnut hole" halved.

The January election in Massachusetts, though, has placed the future of health care reform very much in doubt. The U.S. House of Representatives passed the Affordable Health Care For America Act (H.R. 3962) on November 7, 2009, with a single Republican vote. The Senate passed their version of the bill without a single Republican vote. Both pieces of legislation included substantial Medicaid expansions and changes in Medicaid policy. Federal Funds Information for States estimated the Ohio cost of the Senate Medicaid eligibility expansion provisions to total $349 million between 2017 and 2019. This paper explores the Medicaid provisions contained in the House and Senate reform bills, and identifies policy questions that Ohio and other states will have to explore.

Any expansion of Medicaid eligibility or any of the Medicaid policy changes contained in the legislation will translate into significant implementation responsibilities for states. These added responsibilities will create challenges for Ohio (and every other state) in light of recent state budget cuts, state and county human service employee reductions, insufficient state revenues, and aging technology. At the same time Ohio voters will go to the polls in 2010 to choose a Governor, other statewide elected officials, and members of the Ohio General Assembly. The outcome of those elections could determine when and how health care reform is implemented in Ohio. Among the most significant decisions to be made will be those related to Medicaid.

Medicaid already accounts for nearly 40 percent of the state's General Revenue Fund budget, and the implementation of a Medicaid expansion or

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the provisions described above will increase that percentage. The state would also face a series of policy questions and issues, which include the following.

Which agency or agencies are likely to lead the health care reform effort in Ohio? Will it be run out of the governor's office via the Executive Medicaid Management Administration, or will the Ohio Department of Insurance lead via its Ohio Health Care Coverage and Quality Council, or will some new entity like an Ohio Health Care Exchange be created and charged with leading the effort?

The Ohio Department of Job and Family Services' (ODJFS) Office of Ohio Health Plans is the single state agency for the Medicaid program and will be at the center of Medicaid-related policy questions. But the Ohio Department of Insurance (ODI) under the Strickland administration has taken a much more active role on health care policy issues than in the past. The most recent state budget included insurance reforms sought by the ODI that were projected to result in 100,000 Ohioans gaining coverage. ODI is also leading the Ohio Health Care Coverage and Quality Council which is charged with increasing health care access, improving health care quality and lowering costs. Finally, there is the Executive Medicaid Management Administration (EMMA) which was envisioned as a central coordinating body for management of the Ohio Medicaid program. The EMMA council consists of ODJFS and other cabinet agencies charged with carrying out various aspects of the Medicaid program. EMMA is now being led on an interim basis by Amy Rohling McGee, who also serves as one of Governor Ted Strickland's executive assistants for health and human services. Health care reform may lead to renewed calls for a separate Medicaid agency, or possibly a health authority that includes Medicaid, the envisioned Health Care Exchange, and even EMMA.

The information technology needed within the Ohio Medicaid program to implement this legislation will be significant and costly. It appears, though, that none of the federal reform legislation increases the federal share of costs for information technology or other administrative costs required to implement reform. The Ohio Medicaid program is already deep into the implementation of a new Medicaid payment system (called MITS or Medicaid Information Technology System). This complex system with literally thousands of business requirements is already behind schedule. It seems possible that there could be numerous provisions in the health care reform legislation that would require changes in the MITS system. A big question is whether Ohio can get MITS up and running and stabilized prior to having to incorporate changes required by health care reform. But it's not just the payment system that will be impacted by the legislation. Ohio's aging eligibility system called CRIS-E (Client Registry Information System-Enhanced) would also require significant changes. For example, CRIS-E will be required to exchange information with the not-yet-created Health Care Exchange. There are serious questions about whether this aged system, originally designed as an eligibility system for food stamps, could even handle the new responsibilities. Both of these systems are located within ODJFS, and its information technology budget has often been an executive and legislative target for budget reductions.

County human service departments that have been disrupted by previous state budget cuts will be placed under even greater pressure. It has been estimated that as many as 500,000 Ohioans could be expected to enroll

5 Key Medicaid Health Care Reform Questions for State Policy Makers

1. **Who coordinates the state's health care reform implementation efforts?**
2. **Will state and county governments have the personnel and IT resources sufficient to implement health care reform?**
3. **Should the state move forward with a Medicaid SCHIP expansion or cover these children through a Health Care Exchange?**
4. **How will the state control future Medicaid expenditures in a post-health-care-reform environment?**
5. **How should the state increase or modify its Medicaid waste, fraud, and abuse activities in a post-reform environment?**

in the Medicaid program with the advent of health care reform. This would represent the largest single jump in enrollment since the program began. The potential number of applicants includes both the newly eligible and those who were already eligible and who would now be required to have health insurance or face potential penalties. Here again, the legislation does not provide for any increase in administrative dollars to handle the increased enrollment.

ODJFS will be hard pressed to handle the increase in administrative tasks resulting from health care reform. The agency has eliminated a number of positions over the past two years as a result of state budget cuts. The influx of new Medicaid applicants will result in a marked increase in consumer inquiries, complaints, prior authorization requests, hearings, and provider billing and policy questions. Without additional staffing, response times to these inquiries will likely grow longer, leading to frustration and confusion.

State Medicaid maintenance-of-effort requirements in the legislation could result in budget cuts in other parts of state government, targeted provider rate cuts, an increase in provider taxes, or a combination of all three. Both the House and Senate versions of the reform legislation contain provisions requiring the state to maintain a level of spending by restricting the ability of states to reduce Medicaid eligibility levels from those in effect as of June 16, 2009. This will further limit state budget writers' ability to shrink state Medicaid spending.

Ohio's current Medicaid managed care system will be hard pressed to absorb all the newly eligible into its current system. Its provider networks are already pressed, and it's likely that large provider systems will try to use health care reform as a way to gain some leverage with the large managed care systems. The House version of the legislation recognized some of these potential shortcomings by including a provision that says a state can't require the newly eligible Medicaid individual to enroll in managed care unless the state demonstrates to the Secretary of HHS that there is adequate capacity of the network to meet health, mental health, and substance abuse needs of the individual. If the provision survives, providers will almost certainly insist that the Medicaid managed care plans can't meet the requirement.

Reform will likely mandate that Ohio's Medicaid program cover certain services that are now optional and create new optional categories of service. Ohio's Medicaid program currently covers services mandated by the federal government plus optional services Ohio has chosen to provide. The newly mandatory ones may, in some instances, increase state spending and/or reduce options for reducing spending in the future. The newly optional categories of service likely will result in lobbying by the affected provider groups to include those services in Ohio's state Medicaid plan. Policy makers often don't realize which Medicaid services are optional and which are mandated; these types of provision likely will increase that confusion going forward.

Ohio's behavioral health system could see big changes as a result of health care reform. Both versions of the reform bill include provisions that would mandate that adults with incomes up to 133 percent of the federal poverty level (FPL) be allowed to enroll in state Medicaid programs. This population represents a significant percentage of those currently being served by Ohio's behavioral health system. It would provide many individuals who have serious mental illness with consistent health care coverage for the first time and could lessen expenditures in other areas like emergency rooms. While it will ultimately increase the dollars needed for Medicaid match, it should free up local dollars to provide non-Medicaid eligible services needed by behavioral health consumers. Any significant Medicaid expansion to include childless adults should cause the state to renew its efforts to bring the Medicaid match to the state level.

Ohio Medicaid's disability determination process and its Medicaid Buy In for Workers With Disabilities might have to be revamped. The Office of Ohio Health Plans and the Ohio Rehabilitation Services Commission have been engaged in nearly two years of conversation about unifying their two disability determination processes. There are questions about whether the Medicaid disability determination process would still be needed if individuals could qualify for Medicaid based solely on their income. The Medicaid Buy In for Workers With Disabilities may require changes as well since some of those in the program might have incomes higher than new income limits for Medicaid.

Ohio could benefit from some of the long-term care provisions. For example, the Money Follows the Person program would be extended. ODJFS has used this program to assist long-term residents of skilled nursing facilities to return to the community. The House bill establishes a publicly administered voluntary long-term care insurance program within the Community Living Assistance and Supports (CLASS) provisions. The CLASS program would

Medicaid Basics

Medicaid is Ohio's largest health and long-term care program. It combines state and federal funds to purchase health care coverage for low-income and medically vulnerable citizens. In reality, Medicaid is not one program but many:

- An insurance program for children, parents, pregnant women, older adults, and people with disabilities who meet certain low-income requirements;
- A program of chronic and long-term care for people with disabilities, including people with mental illness and low-income elderly;
- A supplement to Medicare for low-income elderly and people with disabilities; and
- A source of funding for uncompensated care in hospitals.

Medicaid provides, on average, health services to 1.7 million Ohioans every month (15percent of the total population) and a total of 2.2 million people throughout the year. Each month, Medicaid covers:

- 992,000 children (1 out of 3), including 34,000 children with disabilities;
- 340,000 parents;
- 108,000 seniors; and
- 259,000 people with disabilities, including children.

Medicaid pays 64,389 health care providers annually and accounts for 28percent of all hospital and 47percent of all nursing home spending in the state. The program spends $13 billion annually and accounts for 3percent of the Ohio economy. Every dollar the State of Ohio spends on Medicaid generates nearly $2.64 in total health care spending in Ohio.

Source: Ohio Medicaid Basics 2009, the Health Policy Institute of Ohio

pay benefits to eligible persons who require long-term care services. The CLASS program would become the primary payer for long-term care services for Medicaid enrollees, and Medicaid would be the secondary payer. This might help slow the growth of these expenditures at the state level.

Ohio's efforts to reconnect individuals leaving public institutions (state prisons, youth services facilities, state mental health hospitals, and local jails) with Medicaid will likely have to be increased. Nearly all of Ohio's prison population will likely be eligible for Medicaid under either the House or Senate legislation. This will make coordination activities between the counties and state even more important and lead to calls for even greater automation. A rather contorted section of the House bill requires states to assure that youth who were eligible for Medicaid upon being incarcerated must retain eligibility and receive benefits upon release. The bill goes on to say that states are required to ensure they do not claim federal financial participation (FFP) for services excluded by Section 1905(a)(28)(A) of the Social Security Act for these same youth while they are incarcerated, and that states are required to ensure that these same youth receive services for which FFP is available.

There will be significant provider pressure to increase provider payment rates at a minimum for primary care services. The House-passed version of the bill requires that Medicaid reimburse primary care services furnished by physicians and other practitioners at no less than 80 percent of Medicare rates beginning January 1, 2010, 90 percent in 2011, and 100 percent thereafter. There is no similar provision in the Senate bill. According to Federal Funds Information for States (FFIS), Ohio Medicaid reimbursement for physician fees for primary care services averaged about 66 percent of Medicare rates. So a mandated increase in rates would be costly and would reduce state flexibility in the future to manage program costs.

Ohio's one-time proposed expansion of its State Children's Health Insurance Program (SCHIP) to 300 percent of the FPL might not proceed. This is because the health care reform legislation envisions that these children would ultimately obtain their health care coverage through the newly created Health Care Exchange. Likewise, Ohio's Children's Buy In would likely be scrapped, and those uninsured children also would likely be directed towards the Exchange. The downside for children between 200 percent and 300 percent of the FPL is that the coverage or benefits they get through the Exchange will not be as

comprehensive as what they might have gotten through Medicaid/SCHIP.

Ohio's Medicaid/SCHIP program has been very successful in reducing the number of uninsured children living in the state. The most recent Ohio Family Health Survey found that only 4 percent of Ohio children remain uninsured. SCHIP remains politically popular in Ohio and other states even during bad economic times. A study written by Georgetown's Center for Children and Families found that almost half the states, including Ohio, improved their SCHIP program in 2009.

Child advocates are concerned that the House bill would repeal SCHIP in 2013, while the Senate bill would keep SCHIP in place until 2019 with funding continued through 2015, to see whether children get the health care services they need through the newly created Health Care Exchanges. One concern is whether the subsidies provided for in the Exchange will be sufficient for families with children to afford to purchase the required coverage. It's likely that children receiving coverage through the Exchange will be subjected to co-pays that Ohio's SCHIP program does not require.

If the final legislation looks more like the House version, look for provisions requiring states to provide wrap-around Medicaid services to those children who might previously have been covered under SCHIP—creating a new "dual eligible" category, that will be administratively complex.

Under the Senate bill, Ohio could choose to expand Medicaid coverage to childless adults much earlier than the Medicaid expansion dates of January 1, 2013 (U.S. House) or the January 1, 2014 (U.S. Senate). Beginning on April 1, 2010, the Senate bill would provide states the option of covering childless adults and parents of enrolled children through a state Medicaid plan amendment at the 2010 regular federal matching rate of 63.42 percent. This type of expansion was recommended by Ohio's State Coverage Initiative in 2008.

Ohio Hospital Care Assurance Program (HCAP) likely will face dramatic changes. HCAP is Ohio's version of the federal-mandated Disproportionate Share Hospital (DSH) program. DSH was meant to compensate hospitals providing a disproportionate share of care to indigent patients (Medicaid consumers, people below poverty, and people without health insurance). Both the House and Senate versions of the legislation project significant spending reductions in this program based on the assumption that the amount of uncompensated care will be reduced. The Senate bill is projected to reduce Ohio DSH funds anywhere between $139.8 million and $199.7 million. This will likely result in a major fight between hospitals around who pays into and who gets funds out of HCAP in the future if DSH continues.

There are also provisions to change graduate medical education payments. But Community Solutions' Executive Director John Begala argues for a full revamping of graduate medical education policies. He makes the case that health reform should alter these payments so they would significantly increase the number of primary care physicians—especially in underserved urban and rural areas—reduce the rate or growth in subspecialty medicine, and slow the rate of growth in overall health care costs.

Medicaid enrollment is likely to be streamlined and made easier. Both the House and Senate versions of the bill include provisions related to out-stationing of enrollment workers and or presumptive eligibility. The House bill requires the Secretary of HHS to issue guidance regarding standards and best practices for states (e.g., out-stationing of eligibility workers, express lane eligibility, presumptive eligibility, continuous eligibility, and automatic renewal) to facilitate outreach and enrollment of eligible individuals in Medicaid. Both bills envision some type of automatic Medicaid enrollment for individuals found to be Medicaid eligible by a Health Care Exchange. This last provision, if included in a final bill, may raise questions about whether it still makes sense to maintain a Medicaid eligibility determination function at the county level. Of course, removing this function may increase consumer confusion and reduce efforts to enroll individuals in other programs for which they are eligible (e.g., Supplemental Nutrition Assistance Program, more commonly known as food stamps). The Senate also directs the Department of Health and Human Services to create a single form to apply for Medicaid, CHIP, or subsidies in the Exchange.

Legislation may force Ohio to expand or modify its Medicaid coverage for children who aged out of foster care. The Senate would require states to extend Medicaid eligibility to any young adult up to age 25 who previously was in foster care for at least six months. These young adults would be entitled to all benefits under Medicaid, including Early Periodic Screening, Diagnosis and Treatment (EPDST). Also under the House bill, every uninsured newborn would be provided with Medicaid coverage for 60 days while the infant is enrolled in the

appropriate insurance. The federal government would pay 100 percent of the costs of Medicaid coverage for these newborns.

Ohio would benefit from a provision that would allow states to continue their managed care provider taxes. Ohio, like several other states, passed a new managed care provider tax in the most recent state budget, but CMS has not yet approved it. This provision would provide greater certainty at least in the short term.

Ohio likely will have to end or modify its current approach of using earned income disregards. The federal government likely will want all states to use a gross income due to the interaction between Medicaid and the Health Care Exchanges. For example, according to the Senate legislation, as of January 1, 2014, states would no longer be allowed to use income disregards in Medicaid except for people with disabilities, the elderly, and groups that are eligible for Medicaid through another program (e.g., children on foster care). Ohio makes extensive use of income disregards. This provision, if adopted, would require substantial reprogramming of Ohio's Medicaid eligibility information system. It would also make Ohio's Medicaid program inconsistent with Ohio's TANF and child care programs, which continue to allow disregards.

Ohio's waste, fraud, and abuse detection and prevention activities likely will be the subject of intense focus. There is an expectation among policy makers at the federal level that program integrity activities will ultimately lead to savings that can be reinvested in health care coverage. Ohio's efforts in this area are split between a number of state and local agencies and various statewide offices. One positive provision in the House bill would remove a disincentive for states to identify overpayments to Medicaid providers. Currently, when a state discovers that an overpayment has been made, they have 60 days to recover the overpayment. The federal government takes back its share within those 60 days regardless of whether the funds have been recovered. The House would extend the overpayment period to one year. There are a multitude of other provisions, and many of them likely will end up in the final bill and will take months—if not years—to implement.

Ohio's Medicaid program will be under pressure to apply for or participate in the many pilot programs and grants envisioned in health care reform legislation. State agencies are often reluctant to participate in pilot projects because they can be staff intensive and create expectations of long-term support by the state after enhanced federal funds cease. Advocates and others will push hard for the state to pursue such pilots, and the state likely will pursue some of them. Three examples of pilots in the House bill include a five-year Medicaid medical home pilot program for Medicaid eligible individuals, including medically fragile children and high-risk pregnant women, pilots for accountable care organizations, and pilots for stabilization of emergency medical conditions by institutions for mental disease (IMDs).

One of the best short-term advantages of the House legislation is an extension of Ohio's (and every other state) enhanced federal medical assistance percentage (FMAP) for an additional six months. The American Recovery and Reinvestment Act of 2009 provided a temporary FMAP increase for the first quarters of federal fiscal year (FFY) 2009 and ending on December 31, 2010. This one provision could provide Ohio with an estimated $730 million and would be very useful in helping balance the 2012-2013 state budget.

Federal Funds Information for States has estimated the Ohio cost of the Senate Medicaid eligibility expansion provisions to total $349 million between FFY 2017 and FFY 2019. Their estimates are based on numbers released by the U.S. Senate Finance Committee, and do not include the costs of implementing the various policy changes described above. It seems reasonable to believe that actual costs could be higher.

Final Thoughts

Failure to pass health care reform will translate into higher federal deficits and health care costs continuing to increase at unsustainable levels. This will lead to even more difficult policy choices in the future. At the same time though, the Medicaid eligibility expansions and policy changes included in the health care reform legislation will increase state spending in both the short and long term. What isn't known is whether reform will ultimately lead to lower costs in other parts of the state's budget that can offset some of the additional costs. What is clear is that the State of Ohio, with its inadequate current and projected revenue base, will be in no position to absorb these additional costs.

Appendix

The House bill includes a number of Medicaid coverage provisions as described below (effective dates are provided if specified in the legislation). Most of these changes are not included in the Senate version. Those that are addressed by the Senate are noted with an (*) and described in the section that follows.

House Program Requirements:

- prohibit states from using a resource or asset test when determining eligibility for most non-elderly individuals*
- require Medicaid to cover newborns up to the first 60 days (or until determined eligible for Medicaid or other qualified coverage); if, at the end of the 60 days no determination is made, the child is deemed Medicaid eligible (effective January 1, 2013; 100 percent federal match in 2013 and 2014, 91 percent federal match thereafter)
- require Medicaid programs to suspend, not terminate, eligibility for beneficiaries under age 19 who are incarcerated in a public institution; states must ensure youth have access to Medicaid immediately upon release
- prohibit Medicaid programs from excluding tobacco-cessation products from coverage (effective January 1, 2010)*
- require Medicaid to pay Medicare coinsurance and deductibles for Medicare beneficiaries under age 65 (non-elderly disabled) whose income is less than 150 percent FPL but who would otherwise meet the eligibility criteria for Qualified Medicare Beneficiaries (effective January 1, 2013; regular federal matching rate)
- require 12-month continuous eligibility for children with incomes below 200 percent FPL and enrolled in CHIP (effective January 1, 2010)
- require Medicaid programs to cover physician's services by podiatrists (effective January 1, 2010) and optometrists (effective 90 days after enactment)
- expand out-stationing by requiring Medicaid to allow individuals to apply for coverage at hospitals and locations other than welfare offices (effective July 1, 2010; extend requirements to applications for coverage in the exchange beginning in January 1, 2013)
- require Medicaid to cover, without cost-sharing, certain preventive services recommended by the U.S. Preventive Services Task Force (effective July 1, 2010)*
- require Medicaid programs to continue covering non-emergency transportation to medically necessary services as specified in regulations in effect on June 1, 2009 (effective upon enactment)
- require Medicaid to cover citizens of Freely Associated States who are lawfully residing in the state and otherwise eligible for Medicaid
- prevent the application of a coverage waiting period for children under two years of age for whom health coverage is unaffordable (premiums and cost-sharing exceed 10 percent of family income), (effective 90 days after enactment)

State Options:

- provide a state option to disregard income in providing continued Medicaid coverage to individuals with high prescription drug costs
- provide optional Medicaid coverage for low-income HIV-infected individuals (effective upon enactment but sunsets on January 1, 2013; expenditures eligible for CHIP match rate and exempt from Medicaid cap imposed on territories)
- provide optional Medicaid coverage with optional presumptive eligibility determinations for family planning services to non-pregnant individuals with incomes that do not exceed the highest income eligibility for Medicaid or CHIP for pregnant women (effective upon enactment)*
- provide optional Medicaid coverage of home visits by trained nurses to families with first-time pregnant woman or children under two eligible for Medicaid (effective January 1, 2010)
- provide optional Medicaid coverage for free-standing birth center services (effective upon enactment)*

Other Items:

- provide 75 percent federal matching rate for the costs of translation or interpretation services for Medicaid-eligible adults for whom English is not the primary language (effective January 1, 2010)
- extend Transitional Medicaid Assistances (TMA) and Qualifying Individuals (QI) programs through December 31, 2012, and remove annual funding cap for QI (effective January 1, 2011)
- clarify that Medicaid law does not prohibit Medicaid from covering therapeutic foster care for children in out-of-home placements
- prohibit the secretary of HHS from denying federal matching funds to states for the cost of adult day health care services as defined under a Medicaid plan approved during or before 1994 (applies to services provided on or after October 1, 2008)
- require the secretary of HHS to issue guidance on standards and best practices for outreach for Medicaid

and CHIP targeted to vulnerable populations (effective within 12 months of the bill's enactment)

The Senate bill includes changes to Medicaid as well, although it contains fewer provisions than the House bill.

Senate Program Requirements:

- require income eligibility for non-elderly to be determined using modified gross income (MGI); states must submit a plan to HHS outlining the transition to MGI (effective January 1, 2014)
- require CHIP programs to use MGI to determine eligibility (effective January 1, 2014)
- prohibit income disregards and asset/resource tests, except for certain populations such as the elderly and groups eligible for Medicaid through another program (foster care, low-income Medicare beneficiaries, and Supplemental Security Income), (effective January 1, 2014)
- require Medicaid coverage for children under age 26 who have aged out of foster care as of the date of enactment (effective January 1, 2014)
- require coverage for free-standing birth center services (effective upon enactment unless state legislation is required)
- eliminate smoking-cessation drugs, barbiturates, and benzodiazepines from excluded drug list (effective January 1, 2014)
- require states to offer premium assistance and wraparound benefits to Medicaid beneficiaries who are offered employer-sponsored insurance (ESI) if it is cost effective to do so (effective January 1, 2014)
- require states to report annually on changes in Medicaid enrollment by population as well as outreach and enrollment processes (effective January 1, 2015)

State Options:

- provide optional Medicaid coverage with optional presumptive eligibility determinations for family planning services to non-pregnant individuals with incomes that do not exceed the highest income eligibility for Medicaid or CHIP for pregnant women (effective upon enactment)
- provide states that cover certain preventive services recommended by the Preventive Service Task Force and eliminate cost sharing with a 1 percent increase in the FMAP for such services (effective January 1, 2013)

Other Items:

- allow hospitals to make presumptive eligibility determinations for all Medicaid-eligible populations (effective January 1, 2014)
- allow Medicaid-eligible children to receive hospice services concurrent with other treatment.

References:
1. Families USA, *At A Crossroads: Is Health Coverage Ahead for America*, December, 2009.
2. Families USA, *Coverage for American: We All Stand to Gain*, July, 2009.

If you have any questions or topic suggestions for future issues of *State Budgeting Matters*, please contact Jon Honeck, director of Public Policy and Advocacy at jhoneck@CommunitySolutions.com.