

MEDICAID AND VOUCHERS FOR PRIVATE COVERAGE¹

BY LAURA HERMER

While there is much talk about Rep. Paul Ryan's current proposal to make Medicare into a voucher program, little-noticed movements have been growing in certain states to make a similar move with respect to Medicaid. From Texas to Mississippi to Minnesota, some legislators and governors have expressed interest in transforming their Medicaid programs from publicly-provided health coverage which is guaranteed to qualifying beneficiaries, to a voucher program that provides funds, possibly limited in nature, which certain impoverished people could use to help purchase private coverage. What impact would such a transformation have on states, and on the children who comprise nearly half of Medicaid's beneficiaries?

We do have relevant data to help answer these questions. The state of Indiana, in a waiver it received in 2007, sought to promote personal responsibility among beneficiaries and provide a private market solution to the problem of affording coverage for low-income Indianans.¹ Unfortunately, the evidence from Indiana suggests that, rather than offering expanded access to necessary benefits, the strategy of using Medicaid funds to help impoverished Americans purchase private coverage will likely result only in reduced benefits and higher costs for both states and beneficiaries. Healthy Indiana Plan (HIP) enrollees are, and continue to be, both sicker and poorer than regular, privately insured Indianans. None of the available evidence suggests that providing HIP enrollees with state-subsidized, high-deductible private plans, as opposed to Medicaid coverage, has resulted in better or cheaper outcomes for either the state or HIP enrollees than they would have had under Medicaid.²

MEDICAID AND THE ISSUE OF PROVIDER REIMBURSEMENT

Medicaid – the federal/state health insurance program for certain low-income Americans – is a crucial source of coverage for children. It provides a crucial and indispensable public safety net for low-income Americans. Medicaid allows beneficiaries to see providers more readily than if they were uninsured.³ It provides prenatal care and coverage for nearly half of all births in the United States,

¹ Portions of this paper are derived from Laura D. Hermer, *Medicaid, Low Income Pools, and the Goals of Privatization*, 17 GEO. J. ON POVERTY L. & POL'Y 405 (2010).

MEDICAID AND VOUCHERS FOR PRIVATE COVERAGE

and provides financial access to a comprehensive spectrum of both preventive and acute care for over one-third of all children nationwide.⁴ It is designed not only to help ensure that low-income children get the medical screening and preventive care they need to have a healthy start in life, but also so that eligible children and adults whose families lose employer-sponsored coverage – a particularly relevant consideration in today’s economy – can obtain ready, reliable, and retroactive coverage in the event of medical need. Because of Medicaid’s comparatively expansive baseline eligibility for children – the fruit, in large part, of Reagan-era federal expansions – children’s health coverage increased during the 2007-2009 recession, even while adult coverage plummeted.⁵

Yet some claim that exchanging the certainty, stability, and benefits of Medicaid coverage for vouchers for private coverage would be a good thing. Increasingly, they claim, physicians don’t want to accept new Medicaid patients. Additionally, they add, when Medicaid patients do manage to obtain care, they experience worse outcomes than privately insured patients, or even than uninsured patients.⁶ Consequently, they conclude, it would be better to provide Medicaid beneficiaries with vouchers to help them purchase private coverage, rather than providing them with Medicaid coverage.⁷

These claims assume that the relevant variable is private coverage. Studies suggest, however, that the relative generosity with which plans reimburse providers accounts for many of the findings in question, rather than the nature of the coverage in question. If this is true, then it suggests that, all else being equal, similar results could be obtained in traditional Medicaid programs by raising reimbursement rates.

This is borne out in the history of the program. When Medicaid was first enacted in 1965, the Johnson Administration sought to ensure that the poor could access health care “with equal dignity and through similar channels as the medical care of other members of the population.”⁸ It therefore sought robust health care provider participation through encouraging states to adopt generous reimbursement structures. States that complied saw substantial provider participation in Medicaid. However, they also saw a correspondingly rapid escalation in costs.⁹

Medicaid physician reimbursements rose fivefold between 1965 and 1969.¹⁰ Both states and the federal government were alarmed by these rising costs, and sought to bring them in check. For Medicaid’s first two decades, a number of states tried to control costs by changing their reimbursement structures.¹¹ Some states, like California, obtained waivers that allowed increased cost sharing with beneficiaries.¹² Others turned to fee schedules.¹³ Eventually, many states started employing managed care programs.¹⁴ And as reimbursement for Medicaid patients fell relative to that of patients with other third party sources of payment, doctors and hospitals increasingly sought to avoid caring for Medicaid beneficiaries.¹⁵

This continues to be the case today. Numerous studies document that one of physicians’ primary complaints about Medicaid is the comparatively low reimbursement that most states offer, but additionally include other factors such as physician practice type, inordinate payment delays and

MEDICAID AND VOUCHERS FOR PRIVATE COVERAGE

denials, higher prevalence of capitated managed care, and excessive paperwork.¹⁶ Consequently, many physicians are more likely to accept new privately insured patients than Medicaid patients.¹⁷

Yet none of these problems is inherent to Medicaid. As discussed above, Medicaid once did, and could again, pay providers a rate comparable to what they would receive either from Medicare or from private insurers. States could require the entities that administer their Medicaid programs to follow prompt payment laws and give providers either a private right of action or impartial review process for failure to follow the law.¹⁸ They could simplify and reduce paperwork. All of these steps are well within state competence, and none would require shifting Medicaid coverage to the private sector. Paying providers at a higher rate would, however, require spending more money on Medicaid – a step that would, as we will see below, almost certainly be required as well if states wanted instead to turn to private health insurance plans to cover Medicaid beneficiaries.

ATTEMPTING TO DO IT ALL: CAN A STATE PRIVATIZE COVERAGE, CONTROL COSTS, AND EXPAND OR RETAIN COVERAGE AND ACCESS, ALL AT THE SAME TIME?

If Medicaid provided vouchers for private coverage, would it be able to offer less costly but otherwise comparable benefits, more generous provider reimbursement, and either expanded coverage or fewer tax dollars expended, as suggested by some proponents? If so, then it would seem desirable to shift to a voucher system.

All else being equal, plans that reimburse providers more generously than Medicaid necessarily cost more, unless they restrain costs through other means. People have theorized that private health insurance plans, if given the right opportunity, would work more efficiently and effectively than our present system. A number of states have put this to the test in the case of Medicaid. One of these states, Indiana, in fact offers private subsidies for purchasing private coverage to certain low-income uninsured adults, rather than offering them traditional Medicaid. Through the Healthy Indiana Plan (HIP), beneficiaries who otherwise would not be able to afford coverage get it, health care providers get reimbursed at Medicare rates rather than at the generally lower Medicaid rates, and the state – at least according to its original plan – is supposed to pay less than it would if it offered the beneficiaries traditional Medicaid coverage.¹⁹

One problem, however, is that while HIP uses a large amount of the funds that would otherwise be allocated to uncompensated care, it covers only a tiny minority of the state's uninsured population. Indiana originally contemplated covering approximately 127,000 of the state's estimated qualifying 560,000 uninsured individuals with its program.²⁰ Yet, in actual practice, HIP covers far fewer people: at the end of 2009, only 45,460 people, or 5% of the state's uninsured population at that time, had coverage through HIP.²¹

Many Indianans who have no coverage or insufficient coverage will of course still need health care, and many will turn to traditional safety net providers for it. Yet now there is less money available to

MEDICAID AND VOUCHERS FOR PRIVATE COVERAGE

help public hospitals and other safety net providers to offset those costs. Indiana's disproportionate share hospitals agreed to forego \$50 million in DSH payments to help fund HIP, a sum amounting to 40% of the supplemental payments the hospitals would have received.²² But HIP covers only about 5% of Indiana's uninsured population, as just mentioned. The trade-off the public hospitals made is only reasonable if the 5% who are able to take up HIP coverage would have incurred more than \$50 million in uncompensated health care costs at the safety net hospitals, or if any remaining difference is made up through providing compensated care to HIP enrollees who obtain their care at a safety net hospital. The actual impact of HIP on safety net hospital revenues does not appear to have been studied, although one study of the health care safety net system in metropolitan Indianapolis suggests that the diminution of DSH funds by HIP, among other issues, is increasing the financial strain on these providers.²³

Additionally, rather than directly funding care, the money subsidizes a premium payment to a third party, which comes with its own administrative and marketing costs and profit margin to consider. Private HIP plans must limit their administrative costs and profit to 15% of funds that the state appropriates for the program.²⁴ Studies evaluating the cost-effectiveness of existing public versus private health coverage programs have found, in each case that the public programs cost less to administer – approximately 3% for Medicare and 3 to 5% for Medicaid, while administrative expenses for private insurance run approximately two and a half times as high as those of the public programs.²⁵ Lower administrative costs free up more money with which to pay for care.²⁶ This translates across borders: countries with single-payer coverage, such as Canada, for example, spend far less than the United States to administer their coverage systems.²⁷

The extra costs of private coverage translate into fewer people covered with less generous benefit packages that cost more money, as compared with simply providing coverage under the state's regular Medicaid plan. Indiana's HIP, for example, serves non Medicaid-qualifying parents and a limited number of childless adults earning up to 200% FPL.²⁸ HIP offers benefits "similar to the State of Indiana employee benefits plan" (though it excludes maternity, vision, and dental benefits, among others), with a \$1,100 deductible for individuals, a maximum annual benefit of \$300,000, and a lifetime benefit of \$1 million.²⁹ To help meet the deductible, participants are required to contribute between 2% and 4.5 – 5% of their gross family income to a health savings account, with the state paying the remainder.³⁰ According to one study, 10% of HIP beneficiaries lost their coverage because they failed to make their required contribution to their health savings account in the first month.³¹

In its original application to CMS to start HIP, Indiana estimated that the cost to the state of providing HIP to a parent in the first year of the demonstration would be \$336 per month, with an additional 2 to 5% of the parent's gross income added to the sum (between \$0 and \$85.83 per month).³² To provide the parent with a much richer benefit plan under regular Medicaid, including maternity and vision care, and medical transportation costs, with only nominal out-of-pocket costs and no maximum annual or lifetime limits on coverage, would, according to Indiana's own

MEDICAID AND VOUCHERS FOR PRIVATE COVERAGE

estimates, cost the state only \$359.³³ Thus, if one includes the parent's out-of-pocket expenses, Indiana anticipated that it would cost slightly less overall to provide the parent with the richer regular Medicaid benefit package.

Yet Indiana's actual experience has been even more extreme. According to the most recently available data, an average HIP enrollee who did not have a history of cancer, HIV/AIDS, hemophilia, organ transplant or aplastic anemia, cost the state \$412.54 per month between January and August 2009, as compared to adult Medicaid managed care enrollees, who each cost \$350.31.³⁴ HIP enrollees with cancer or another of the listed medical conditions are placed in a separate enrollment group and cost far more: \$1,007.02 per month per patient, on average.³⁵ Yet Medicaid enrollees with HIV, cancer, and other conditions are included in the group who cost \$350.31 per month. Accordingly, the state has ratcheted back on HIP participation by non-caretaker adults, who tend to be older and have more chronic diseases and other illnesses than HIP parents.³⁶ As of July 31, 2010, the number of non-caretaker adults with coverage through HIP had been reduced by nearly 10,000 to 18,284, with over 51,000 on a waiting list.³⁷

It is difficult to justify spending so much more for HIP coverage than it would cost to provide comparably more generous benefits under Medicaid, yet those were, remarkably, not the only costs expended under HIP: many beneficiaries had to contribute up to 5% of their income to help fund a health savings account intended to cover the \$1,100 deductible.³⁸ These out-of-pocket costs may act as a barrier to participation for parents, who tend to have comparatively better health status than the HIP non-caretaker participation: as of June 2009, only 18,017 parents had taken up coverage – less than half of HIP's target for the year.³⁹

This is not to say, however, that HIP parents do not need health care – their health status is worse than that of people with regular private coverage.⁴⁰ HIP parents, like non-caretaker HIP adults, used comparatively more health care than the regular, privately insured population. A study by Milliman found that HIP parents had more than 1.6 times as many inpatient hospital visits as the regular, privately insured population, and 2.8 times as many emergency room visits.⁴¹

Providing an entire state's Medicaid population with coverage such as that offered under HIP would be far more expensive to a state, despite the limited benefits package. To remove HIP's annual and lifetime limits on expenditures, and include basic benefits not included under HIP, such as maternity care for women and the expansive care for children offered through Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, would add substantially to those costs. Holding costs down would require even stricter limits on eligibility, services, and benefits than those already extant under HIP. The net effect of such limits would be to transfer the cost of health care from states to their impoverished and most vulnerable residents, including the one out of every three American children who currently receive their coverage through Medicaid.

CONCLUSION

MEDICAID AND VOUCHERS FOR PRIVATE COVERAGE

Proposals to change Medicaid into a voucher program make little sense if their goal is to subsidize the purchase of private coverage that will then afford recipients expanded ease of access to providers and adequate benefits. With relaxed standards and scarce dollars going not towards coverage but towards marketing, profit, and other extraneous matters, Medicaid would lose the characteristics that have made it the most important piece of America's safety net. The taxpayer dollars that fund Medicaid should be used to provide care for beneficiaries, rather than providing profit to private plans.

NOTES

¹ INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, THE HEALTHY INDIANA PLAN §1115 AFFORDABLE CHOICES DEMONSTRATION PROPOSAL 9 (2007), available at <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Healthy%20Indiana%20Plan%20Historical%20Documents.zip>.

² A report from Mathematica Policy Research, Inc., detailing HIP enrollees' health status, access to care, and satisfaction with coverage, among other factors, was due to be submitted to the Centers for Medicare and Medicaid Services (CMS) late last spring. However, as of this writing, the report was still under review by Indiana's Family and Social Services Administration, and has not yet been released. See, e.g., INDIANA LEGISLATIVE SERVICES AGENCY, THE HEALTHY INDIANA PLAN AND HEALTH COVERAGE OF CHILDLESS ADULTS ACROSS THE STATES 3-4 (2011), available at www.in.gov/legislative/publications/Healthy_Indiana_Plan.pdf.

³ See, e.g., Brent R. Asplin, Karin V. Rhodes, Helen Levy et al., *Insurance Status and Access to Urgent Ambulatory Care Follow-Up Appointments*, 294 JAMA 1248, 1251 (2005).

⁴ NATIONAL GOVERNORS' ASS'N, MATERNAL AND CHILD HEALTH STATISTICS, FY 2008 (2009), available at <http://www.nga.org/Files/pdf/1001MCHFY2008.PDF>; KAISER COMM. ON MEDICAID AND THE UNINSURED, HEALTH COVERAGE OF CHILDREN: THE ROLE OF MEDICAID AND CHIP (2011), available at <http://www.kff.org/uninsured/7698.cfm>.

⁵ KAISER COMM. ON MEDICAID AND THE UNINSURED, *supra* note 5.

⁶ See, e.g., HOUSE COMMITTEE ON THE BUDGET, THE PATH TO PROSPERITY: RESTORING AMERICA'S PROMISE 39-40 (2011), available at <http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf>.

⁷ See, e.g., Warren Wolfe, *DFL, GOP Both Open to Deal on Health Vouchers*, MINNEAPOLIS STARTRIBUNE, April 20, 2011, available at <http://www.startribune.com/politics/statelocal/120327504.html>; Marc Caputo, *HMOs Could Control \$22 Billion in Spending Under Medicaid Reform*, MIAMI HERALD, May 5, 2011, available at <http://www.miamiherald.com/2011/05/05/2203582/hmos-could-control-22-billion.html>.

⁸ Robert Stevens & Rosemary Stevens, *Medicaid: Anatomy of a Dilemma*, 35 LAW & CONTEMP. PROBS. 348, 384 (1970).

⁹ *Id.* at 384-85.

¹⁰ *Id.*

¹¹ *Id.* at 267-69.

¹² See, e.g., *Cal. Welfare Rights Org. v. Richardson*, 348 F. Supp. 491, 495 (N.D. Cal. 1972).

¹³ JONATHAN ENGEL, POOR PEOPLE'S MEDICINE: MEDICAID AND AMERICAN CHARITY CARE SINCE 1965 177 (2006).

¹⁴ ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* 268-69 (Transaction Publishers 2d ed. 2003); Maren D. Anderson & Peter D. Fox, *Lessons Learned from Medicaid Managed Care Approaches*, 6 HEALTH AFF. 71, 74 (1987).

¹⁵ STEVENS & STEVENS, *supra* note 15, at 201-02 (discussing physician Medicaid boycotts over payments in the early 1970s); Frank Sloan, Janet Mitchell & James Cromwell, *Physician Participation in State Medicaid Programs*, 13 J. HUM. RESOURCES 211, 238-39 (1978) (finding that low Medicaid fee schedules and increased hassle in obtaining reimbursement were the most important factors in inducing physicians not to participate in Medicaid); Janet B. Mitchell, *Physician Participation in Medicaid, Revisited*, 29 MED. CARE 645, 650 (1991) (finding that the share of the average physician's Medicaid practice declined from 12.1% in 1977-78 to 9.5% in 1984-85).

¹⁶ Stephen M. Davidson, Janet D. Perloff, Philip R. Kletke et al., *Full and Limited Medicaid Participation Among Pediatricians*, 72 PEDIATRICS 552, 556 (1983); Janet D. Perloff, Philip Kletke, & James W. Fossett, *Which Physicians Limit Their Medicaid Participation, and Why*, 30 Health Serv. Res. 7, 15-20 (1995); Steve Berman, Judith Dolins, Suk-fong Tang et al., *Factors that Influence the Willingness of Primary Care Pediatricians to Accept More Medicaid Patients*, 110 PEDIATRICS 239, 243 (2002); Peter J. Cunningham & Len M. Nichols, *The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective*, 62 MED. CARE RES. & REV. 676, 687-89 (2005).

¹⁷ Peter Cunningham & Jessica May, *Medicaid Patients Increasingly Concentrated Among Physicians*, CENTER FOR STUDYING HEALTH SYSTEM CHANGE TRACKING REPORT NO. 16 (2006), available at <http://www.hschange.com/CONTENT/866/866.pdf>; Ellyn Boukus, Alwyn Cassil, & Ann S. O'Malley, *A Snapshot of U.S. Physicians: Key Findings from the 2008 Health Tracking Physician Survey*, CENTER FOR STUDYING HEALTH SYSTEM CHANGE DATA BULLETIN NO. 35 (2010).

¹⁸ Prompt payment laws are laws that require insurers doing business in a state to pay "clean," or properly completed, claims for payment within a specified period of time, usually 30 days. *See, e.g.,* Monica E. Nussbaum, *Prompt Pay Statutes Should Be Interpreted to Grant Providers a Private Right of Action to Seek Enforcement Against Payors*, 15 HEALTH MATRIX 205, 209-12, 231 (2005).

¹⁹ Letter from Kerry Weems, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., to E. Mitchell Roob, Sec'y, Ind. Family & Soc. Servs. Admin. 2 (Dec. 14, 2007), available at <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Healthy%20Indiana%20Plan%20Current%20Approval%20Documents.pdf>; INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, *supra* note 2, at 27.

²⁰ INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, *supra* note 2, at attachment 6, p. 8. Elsewhere, the document states that the State's goal is to cover up to 150,000 presently uninsured people. *Id.* at 5.

²¹ CAROL IRVIN, *HEALTHY INDIANA PLAN: THE FIRST TWO YEARS* 12 (2010), available at http://www.mathematica-mpr.com/publications/redirect_PubsDB.asp?strSite=PDFs/health/healthyIndiana_Irvin.pdf.

²² *Id.* at 41-42.

²³ MILLICENT FLEMING-MORAN, P. JOSEPH GIBSON, ET AL., *THE HEALTHCARE SAFETY NET OF METROPOLITAN INDIANAPOLIS* 35 (2008), available at www.mchd.com/pdf/epi_safetynet_1208.pdf.

²⁴ INDIANA LEGISLATIVE SERVICES AGENCY, *supra* note 3, at 6.

²⁵ CARLOS ANGRISANO ET AL., MCKINSEY GLOBAL INSTITUTE, *ACCOUNTING FOR THE COST OF HEALTH CARE IN THE UNITED STATES* 72-74 (2007), available at http://www.mckinsey.com/mgi/reports/pdfs/healthcare/MGI_US_HC_fullreport.pdf. *See generally* CONGRESSIONAL BUDGET OFFICE, *CBO'S HEALTH INSURANCE SIMULATION MODEL* (2007), available at www.cbo.gov/ftpdocs/87xx/doc8712/10-31-HealthInsurModel.pdf.

²⁶ See *Time for Change: The Hidden Costs of a Fragmented Health Insurance System: Testimony Before the S. Spec. Comm. on Aging*, 108th Cong. (2003) (statement of Karen Davis, President, Commonwealth Fund).

²⁷ Steffie Woolhandler, Terry Campbell & David U. Himmelstein, *Costs of Health Care Administration in the United States and Canada*, 349 NEW ENG. J. MED. 768 (2003); CARLOS ANGRISANO ET AL., *supra* note 26.

²⁸ INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, *supra* note 2, at 18. The state planned to limit enrollment for childless adults at 11% of the total eligible population. *Id.* at 42. It reached the cap in June 2009. Shari Rudavsky, *Healthy Indiana Plan Quickly Hits Limit for Childless Adults*, INDY.COM, June 4, 2009, <http://www.indy.com/posts/healthy-indiana-plan-quickly-hits-limit-for-childless-adults>.

²⁹ INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, *supra* note 2, at 25, 27. Coverage of up to \$500 is permitted below the deductible for preventive care. *Id.* at 11.

³⁰ *Id.* at 30-31. Parents' contributions are capped at 4.5%, and childless adults' at 5%. See also, e.g., Indiana Family and Social Services Admin., *About the Plan*, available at <http://www.in.gov/fssa/hip/2344.htm> (last viewed May 8, 2011).

³¹ Irvin, *supra* note 22, at 25.

³² INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, *supra* note 2, at attachments 4 & 6.

³³ *Id.* at attachment 6, p. 5; INDIANA OFFICE OF MEDICAID POLICY & PLANNING, INDIANA CARE SELECT PROGRAM DESCRIPTION AND COVERED BENEFITS (2008), available at <http://www.indianamedicaid.com/ihcp/CareSelect/content/documents/62atte.pdf>.

³⁴ INDIANA OFFICE OF MEDICAID POLICY & PLANNING, QUARTERLY FINANCIAL REVIEW 7 (2009), available at http://www.in.gov/fssa/files/OMPP_August_QFR_FINAL.pdf.

³⁵ *Id.*

³⁶ IRVIN, *supra* note 22, at 19-20.

³⁷ TIMOTHY K. LAKE, VIVIAN L. H. BYRD, & SEEMA VERMA, HEALTHY INDIANA PLAN: LESSONS FOR HEALTH REFORM 3 (2011), available at http://www.mathematica-mpr.com/publications/redirect_PubsDB.asp?strSite=PDFs/health/healthyindianaplan_ib1.pdf.

³⁸ INDIANA OFFICE OF MEDICAID POLICY & PLANNING, *supra* note 35, at 30-31.

³⁹ INDIANA OFFICE OF MEDICAID POLICY & PLANNING, HIP MONTHLY DASHBOARD DRAFT (2009) (on file with the author). For studies examining the effect of subsidies on health insurance take-up rates by income and prior insurance status, see generally M. Susan Marquis et al., *Subsidies and the Demand for Individual Health Insurance in California*, 39 HEALTH SERVICES RES. 1547 (2004); David Auerbach & Sabina Ohri, *Price and the Demand for Nongroup Health Insurance*, 43 INQUIRY 122 (2006); Jonathan Gruber & Larry Levitt, *Tax Subsidies for Health Insurance: Costs and Benefits*, 19 HEALTH AFFAIRS 72 (2000).

⁴⁰ IRVIN, *supra* note 22, at 19-20.

⁴¹ ROB DAMLER, EXPERIENCE UNDER THE HEALTHY INDIANA PLAN: THE SHORT-TERM COST CHALLENGES OF EXPANDING COVERAGE TO THE UNINSURED 2 (2009), available at <http://publications.milliman.com/research/health-rr/pdfs/experience-under-healthy-indiana.pdf>.

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