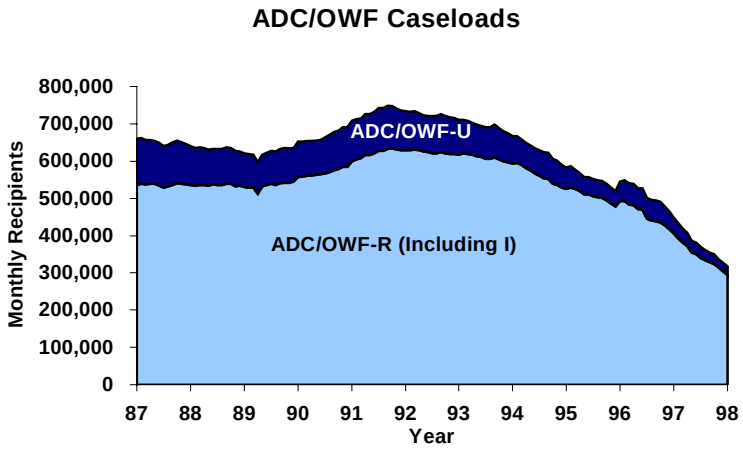
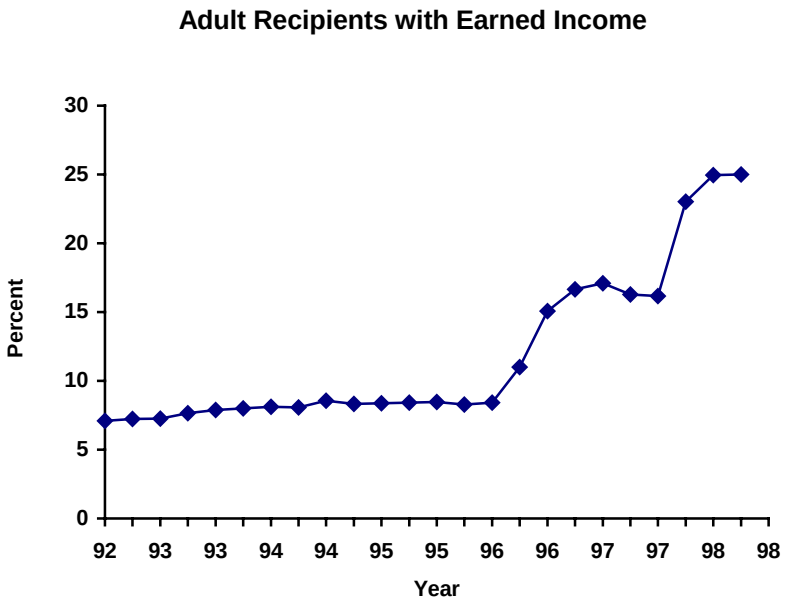
Ohio Works First Caseload Reaches Historic Low



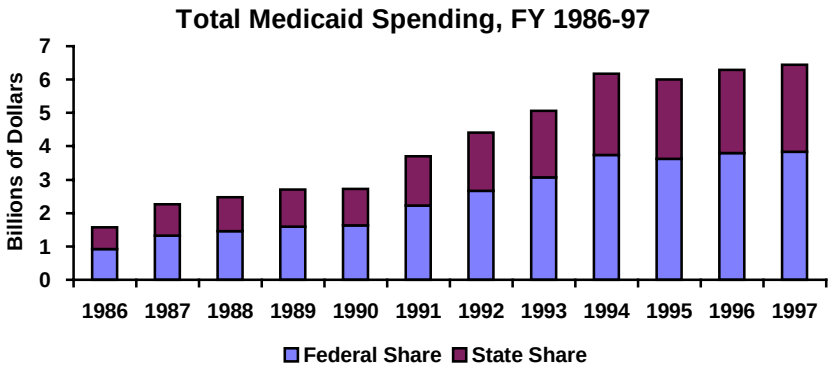
- There are three primary categories of recipients in the Ohio Works First (OWF) program (formerly known as Aid to Dependent Children, or ADC): 1) OWF-Regular (OWF-R); 2) OWF-Unemployed (OWF-U); and 3) OWF-Incapacitated (OWF-I).
- Typically OWF-R cases are households with a single parent or "child only" cases where no adult in the household is receiving OWF benefits. OWF-U cases are typically households with two parents where economic deprivation results from unemployment. OWF-I indicates some incapacity to work for the child caregiver.
- Ohio's ADC/OWF caseload peaked in March 1992 at nearly 749,000 recipients, with an average monthly cash benefit expenditure in FY 1992 of $81.1 million. In June, 1998 the number of recipients declined to about 342,000. The average monthly cash benefit expenditure in FY 1998 declined to $46.0 million.
- OWF-U cases declined as a proportion of the overall caseload from 13.5 percent in July 1987 to 3.9 percent in July 1998. During the recession of the early 1990s, OWF-U cases as a proportion of the total unemployment in Ohio peaked at 8.1 percent. By June 1998 this proportion had declined to 2.0 percent.

Percentage of ADC/OWF Adults with Earned Income Reflects Policy Changes in Welfare Reform



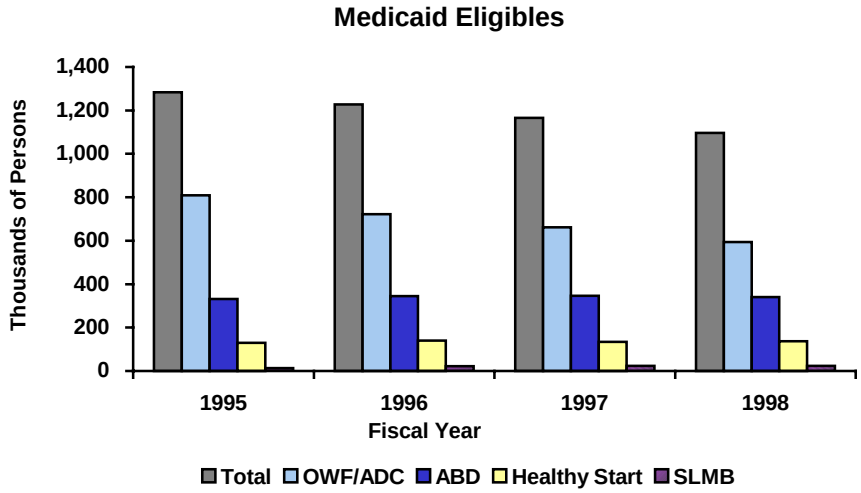
- Earned income disregards, which allow recipients to keep part of their earned income without losing a corresponding amount of the welfare benefit, have been expanded as part of welfare reform.
- The federal Family Support Act of 1988 provided for a disregard of $90 a month for work expenses, the first $30 of income for 12 months, and 1/3 of remaining income for 4 months.
- Ohio H.B. 167, implemented July 1996, increased the disregard to the first $250 and ½ of the remaining income for 12 months.
- Ohio H.B. 408, implemented October 1997, extended the $250 and ½ disregard from 12 to 18 months.
- These changes, along with OWF work requirements, have resulted in a much greater percentage of employed OWF recipients.

Total Medicaid Spending Growth Slows in the Second Half of the 1990s



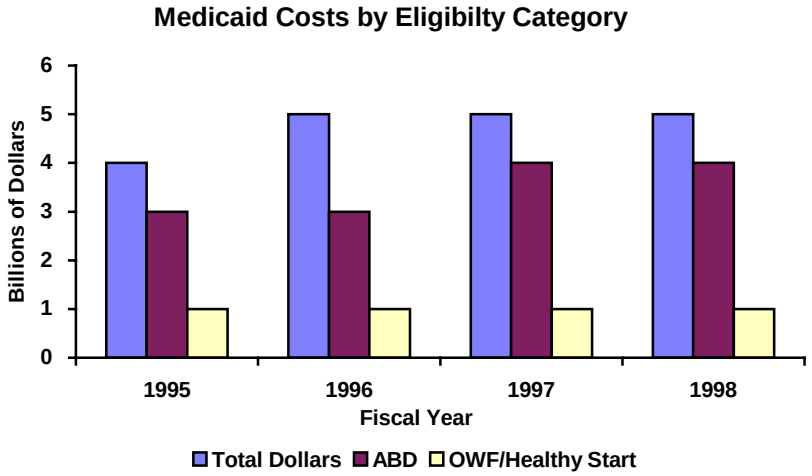
- Since FY 1986, Medicaid spending has increased by an average of 14.6 percent each fiscal year. However, since the high spending growth years of the early 1990s (driven by rapid health care cost increases generally, and specifically by increased caseloads associated with eligibility expansions) Medicaid spending growth has averaged only 6.6 percent between 1994 and 1997.
- Federal and state shares have remained relatively stable at roughly a 60 percent/40 percent split. The ratio is based on a formula that compares Ohio's average per capita income (over a three-year period) to the average per capita income of the entire nation (over the same time period).
- Increases in spending on long-term care and inpatient hospital services for the Aged, Blind, and Disabled (ABD) Medicaid population have been the driving force behind the GRF spending increases. Also contributing significantly to total Medicaid spending (although non-GRF) is the growth of the disproportionate share payment program for hospitals.
- Spending decreased slightly in FY 1995 as the result of an improving economy and savings from a prospective reimbursement system for long-term care, which was introduced in FY 1993.
- On average, only 3 percent of all Medicaid spending in Ohio goes toward the administration of the program. Thus, Ohio has one of the lowest administration to total spending ratios in the country.

Medicaid Eligibility Decreases Due to OWF/ADC Decline



- Although OWF/ADC Medicaid eligibility has declined in recent years, due primarily to the decline in the OWF/ADC cash assistance caseload, it remains the largest Medicaid eligibility group, representing nearly 55 percent of all eligibles in FY 1998.
- OWF/ADC caseloads declined 33.5 percent from the FY 1992 decade high to its lowest level in FY 1998. Until recently, the other major components of the Medicaid caseload had been increasing; however, that appears to be changing, with the Aged, Blind, and Disabled (ABD) population which had average growth of 5.9 percent in the 1990s, declining by 1.9 percent from FY 1997 to FY 1998.
- Yearly expansions of the Healthy Start eligibility category have resulted in a steady increase in the number of low-income children covered by Medicaid. The expansion is the result of OBRA 90, which required states to expand Healthy Start coverage to include children ages 6 through 18 in families with incomes up to 100 percent of the federal poverty line by phasing in one age group each federal fiscal year (14 year-olds were added in 10/97). The Healthy Start population dropped by 4.2 percent in 1997, but is growing by 2 percent in FY 1998 due to the age expansion. The Healthy Start population is expected to grow at a faster rate, as the FY 1998 move to the 150 percent FPL expansion attracts more eligible children into the program.

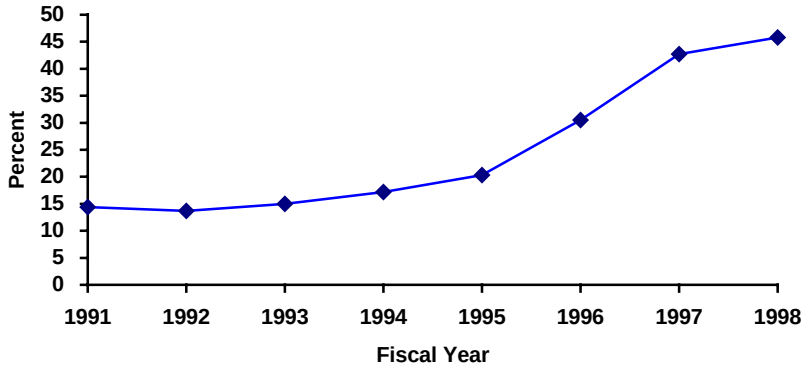
Medicaid Caseload Composition Shifts Toward the Aged, Blind & Disabled



- The decline in cash assistance eligible consumers in Ohio Works First (OWF) has caused a change in the Medicaid caseload composition. Healthy Start (HS) and OWF eligibles have similar cost attributes.
- Aged, Blind, and Disabled (ABD) eligibles comprised less than 28 percent of the more than 1.2 million Medicaid eligibles in FY 1996, yet generated over 70 percent of all care-related Medicaid costs. By 1998 however, the ABD population comprised 32 percent of the nearly 1.1 million Medicaid eligibles and generated about 76 percent of Medicaid spending. The cost of long-term care is the primary reason for the relative expense of the ABD population. This increase in the ABD population is a result of a natural shift and not the result of any policy changes.
- In addition, the ABD population heavily utilizes some of the services with fastest growing costs, such as prescription drugs. Thus, while we have experienced a slowing down in expenditure growth, the change in caseload composition could trigger bigger increases in the near future.
- Ohio's Medicaid program has paid the Part B Medicare premiums for Specified Low-Income Medicare Beneficiaries (SLMBs) since FY 1993. Growth in the SLMB population, which averaged 86.5 percent between 1995 and 1996, has now slowed to 3.9 percent since 1996.

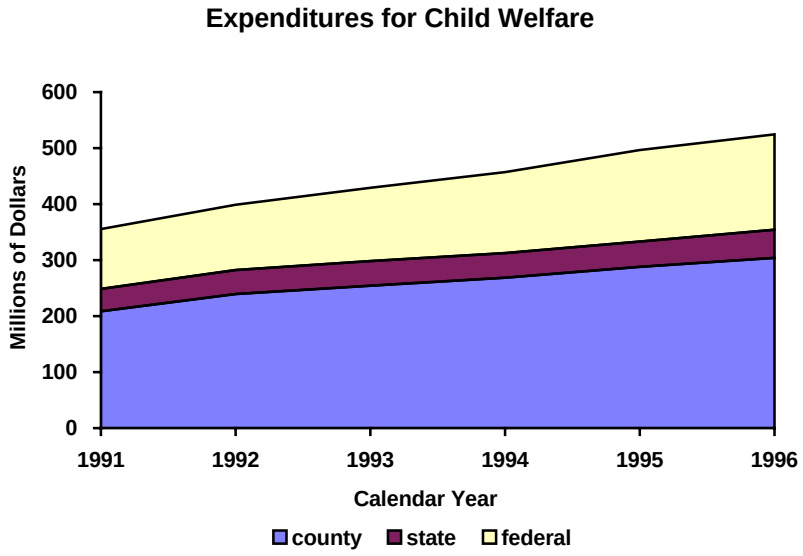
Medicaid Moves Towards Managed Care

Percent of OWF/ADC and Healthy Start Eligibles Enrolled in HMOs



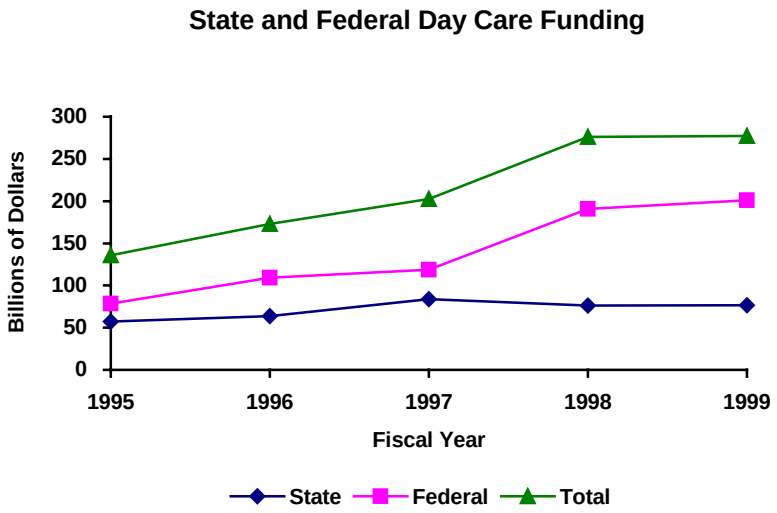
- In January 1995, Ohio received a federal waiver permitting mandatory enrollment of ADC and Healthy Start Medicaid eligibles in HMOs. Ohio's Medicaid program has utilized managed care in a few counties on a voluntary basis since 1978 as a means to ensure access to care, cost predictability and improve forecast reliability.
- By the end of FY 1997, the Ohio Department of Human Services had 55 percent of all OWF/ADC and Healthy Start Medicaid eligibles enrolled in HMOs. The rapid drop in OWF/ADC caseloads has forced HMO enrollment down to about 51 percent in March 1998.
- Enrolling in an HMO up until December 1, 1998 is optional for OWF/ADC and Healthy Start Medicaid eligibles in 9 counties, and mandatory in another 7 counties. Effective December 1, 1998, enrollment is expected to be mandatory in those 16 counties.
- Of the 16 counties either offering or requiring HMO enrollment, Cuyahoga County Medicaid eligibles have the most HMOs from which to choose. There are currently 5 HMOs serving Medicaid eligibles in the Cleveland metropolitan area.

Child Welfare Spending on the Rise
Shares Remain Constant



- From CY 1991 to CY 1996, the total expenditures for child welfare (of which foster care and adoption are significant portions) increased from approximately $355.6 million to $524.8 million, an increase of 47.5 percent.
- Historically, the largest contributors for financing the child welfare system has been the county governments. The county share of these expenditures has averaged nearly 60 percent for years.
- Historically, the state share amounted to no more than 10 percent and the federal share amounted to nearly 30 percent.

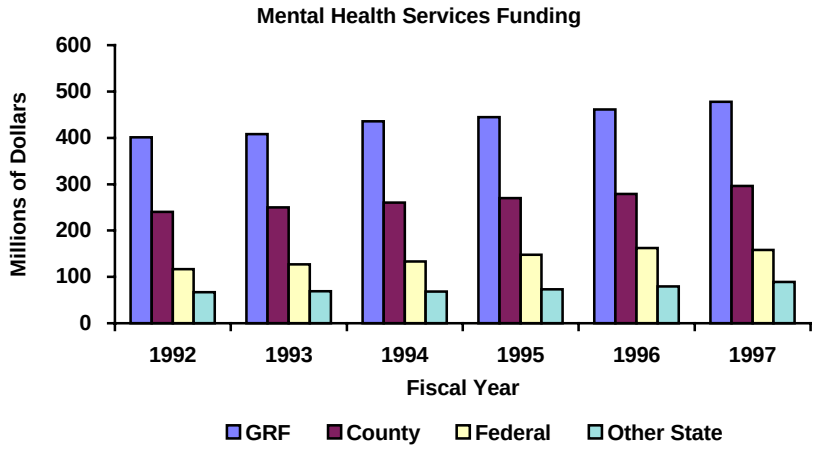
Federal Share of Day Care Funding Increases



**Funding for fiscal years 1995 through 1997 reflect actual expenditures; while funding for fiscal years 1998 and 1999 reflect estimated expenditures.*

- From FY 1995 through FY 1999 total state and federal funding for the delivery of child day care services has increased from $135.7 million to $277.4 million, thus reflecting a 104.3 percent increase over the five-year period.
- The state share of child day care funding has remained relatively flat over this five-year period.
- Over this five-year period, the federal share of child day care funding has increased by 156.4 percent. The Federal Personal Responsibility and Work Act of 1997 provided the states with the flexibility to use several federal funding sources for the provision of child day care services.
- Funding for Ohio's two distinctly separate day care programs, one for welfare recipients and the other for the working poor, are now funded by the same revenue streams.

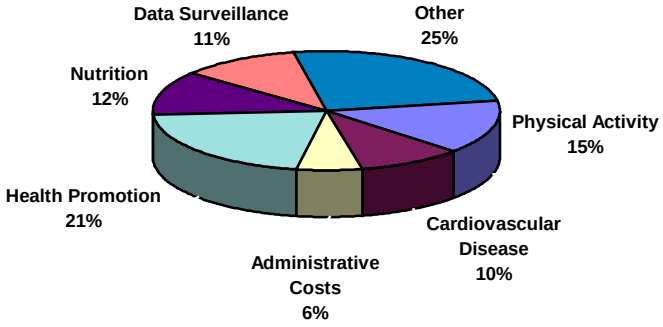
Statewide Funding for Mental Health Services



- Mental health services are provided at six psychiatric hospitals (nine sites) operated by the Department of Mental Health (DMH), 43 community Alcohol, Drug Addiction, and Mental Health Services Boards, and seven community Mental Health Services Boards.
- The average daily resident population at state psychiatric hospitals decreased from 3,147 in FY 1990 to 1,707 in FY 1995, and to 1,281 in FY 1997.
- Forensic patients made up approximately one-third of the daily hospital population in FY 1995 and approximately one-half of the population in FY 1997.
- The Departments of Rehabilitation and Correction (DRC) and Youth Services (DYS) provide mental health services to adult offenders and juvenile offenders, respectively. The Rehabilitation Services Commission (RSC) provides job training to individuals disabled by a mental illness.
- Spending for mental health related services in FY 1997 was $45.5 million for DRC, $1.5 million for DYS, and $22.9 million for RSC.

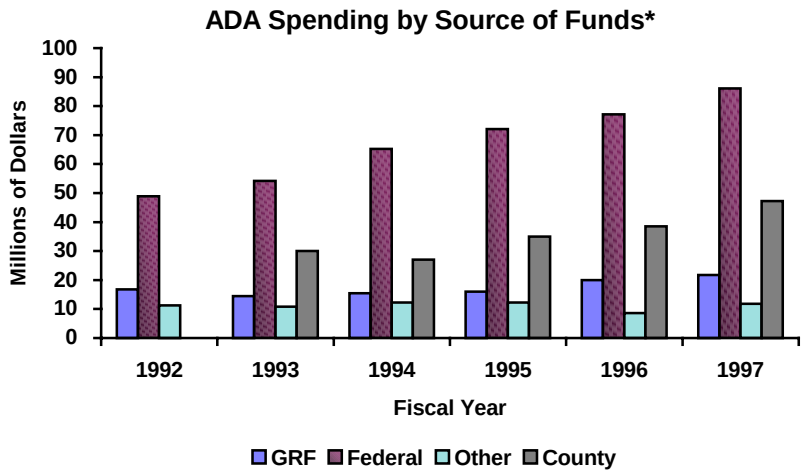
FFY 1999 Preventive Health & Health Services Block Grant

Proposed FFY 1999 Program Budgets



- DOH expects to award grants to 168 local agencies in Federal Fiscal Year (FFY) 1999 to cover projects addressing good nutrition, increasing physical activity, decreasing tobacco use, and preventing rape, among others.
- The Department of Health (DOH) estimates the basic FFY 1999 block grant award to be $6.5 million. DOH estimates an additional $2 million for rape prevention education programs. Each award is made for a 24 month period. Unspent funds from one fiscal year may be used in the following fiscal year.
- Other includes: Intentional Injury (2 percent), Unintentional Injury (8 percent), ElderHealth (2 percent), Environmental Health (2 percent), Tobacco (6 percent), and Emerging Infections (6 percent).
- Ohio's FFY 1999 State Plan is structured to address the goals and objectives set out in Healthy People 2000, as well as the unique health priorities within the state.
- Administrative costs may total no more than 10 percent of the grant award.
- The rape prevention portion of the block grant has increased from $1.5 million in FFY 1997 to $1.8 million in FFY 1998. The main portion of the block grant award has decreased from $6.8 million in FFY 1997 to $6.5 million in FFY 1998.
- The funds in the FFY 1999 block grant will fund year three of a three-year project period for these agencies.

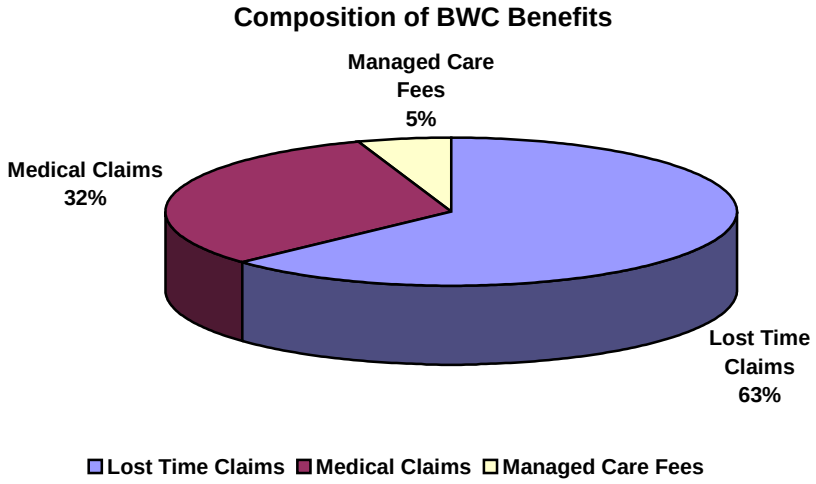
Substance Abuse Services: Federal Dollars Make Up Majority of Spending



* County spending data not collected in FY 1992.

- A total of 93,522 individuals were admitted to a publicly funded treatment program in FY 1997. Alcohol was the primary drug of choice for 56.4 percent, 19.2 percent preferred crack cocaine, and 17.8 percent preferred marijuana.
- Most service provision takes place at the local level through the 43 community Alcohol, Drug Addiction, and Mental Health Services Boards or seven community Alcohol and Drug Addiction Services Boards.
- Substance abuse services to adult offenders and juvenile delinquents are provided by the Department of Rehabilitation and Correction (DRC) and the Department of Youth Services (DYS), respectively. The Rehabilitation Services Commission (RSC) provides job training services for persons disabled by a substance abuse problem.
- Spending for substance abuse services in FY 1997 was $5.7 million for DRC, $2.6 million for DYS, and $3.4 million for RSC (FFY 1997). Both state and federal dollars were used by each agency.

$1.7 Billion in Benefits Paid by the Bureau of Workers' Compensation



- BWC paid $1.7 billion in total benefits in Calendar Year 1997.
- During Calendar Year 1997, BWC paid out $1.1 billion in Lost Time benefits alone. Lost Time benefits are wage replacement payments granted to claimants who miss more than seven days of work as a result of their injuries.
- Total medical costs for the period were $614 million, about 37 percent of the total cost of claims on BWC's State Insurance Fund. Many workers' comp awards include lost time and medical expenses; however, injured workers who miss seven days or fewer from work are eligible for medical benefits only.
- BWC began to phase in the Health Partnership Program (HPP), the agency's managed care initiative over the calendar year. BWC paid some $88 million in fees—about 5 percent of total claims costs—to the 57 participating Managed Care Organizations (MCOs).