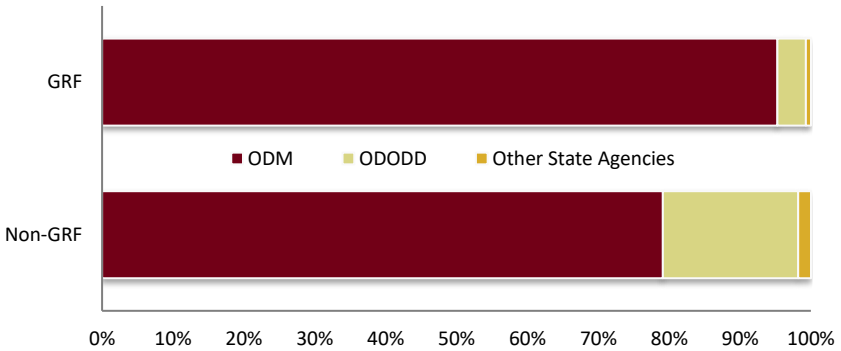


## Department of Medicaid Disburses the Majority of Payments for Ohio Medicaid

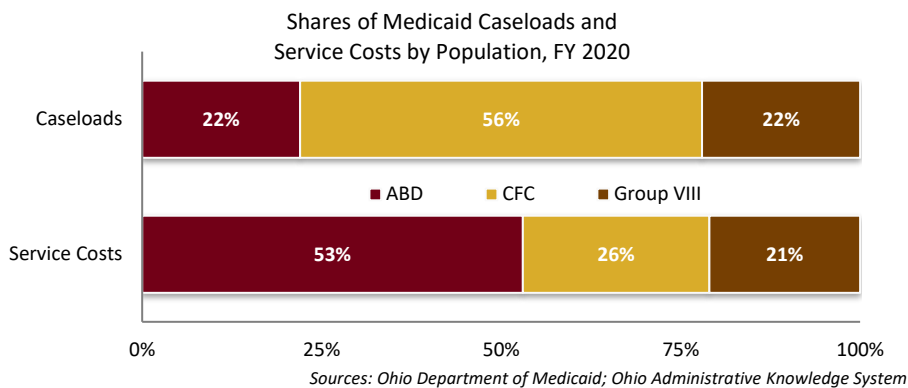
Medicaid Expenditures by Agency, FY 2020



*Source: Ohio Administrative Knowledge System*

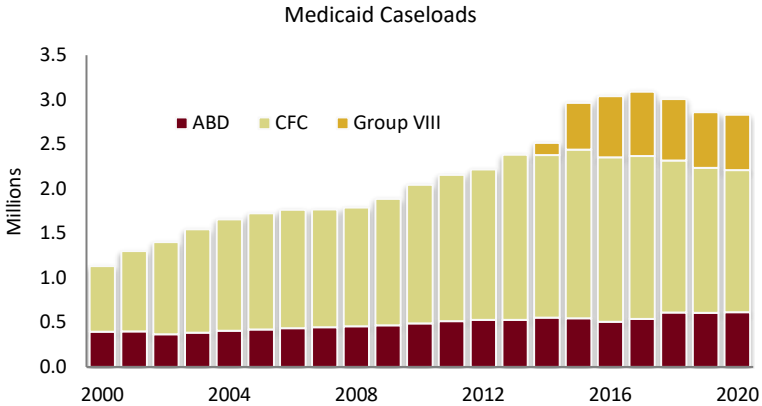
- GRF Medicaid expenditures were \$15.5 billion in FY 2020, of which 95.3% (\$14.7 billion) was disbursed by the Ohio Department of Medicaid (ODM). Non-GRF Medicaid expenditures were \$12.8 billion in FY 2020, of which 79.1% (\$10.1 billion) was disbursed by ODM. Across all funds, Medicaid expenditures totaled \$28.2 billion. ODM accounted for 88.0% of this total.
- Ohio Medicaid is administered by ODM with the assistance of seven other state agencies – Developmental Disabilities, Job and Family Services, Mental Health and Addiction Services, Health, Aging, Education, and the Pharmacy Board – as well as various local entities.
- The Ohio Department of Developmental Disabilities (ODODD) had the second largest share of Medicaid expenditures, accounting for 4.0% (\$624.6 million) of the GRF total, 19.1% (\$2.4 billion) of the non-GRF total, and 10.9% of the all funds total. Together, ODM and ODODD accounted for 98.8% of the all funds total. The remaining 1.2% was accounted for by the other six agencies.
- GRF Medicaid expenditures are paid with a combination of state and federal resources. Of the \$15.5 billion, GRF Medicaid expenditures in FY 2020, \$10.6 billion (68.4%) came from federal reimbursements and \$4.9 billion (31.6%) was funded with state resources.
- The practice of depositing federal Medicaid reimbursements into the GRF started in FY 1976. Since then, GRF appropriations for Medicaid have included both state and federal dollars.
- In FY 2020, the federal government reimbursed 70.1% of all Medicaid expenditures. The state was responsible for the remaining 21.9% of Medicaid expenditures.

## Aged, Blind, and Disabled Account for 22% of Medicaid Caseloads but 53% of Service Costs



- In FY 2020, the aged, blind, and disabled (ABD) population made up 22% of the Medicaid caseloads in Ohio, but accounted for 53% of the service costs. In contrast, the covered families and children (CFC) population made up 56% of caseloads, but only contributed 26% of the service costs. Lastly, the Medicaid expansion population (Group VIII) represented 22% of caseloads and 21% of service costs.
- In FY 2020, Ohio Medicaid caseloads totaled about 2.8 million. Of this, about 614,000 were ABD, 1.6 million were CFC, and 621,000 were Group VIII. Of the \$26.6 billion in total Medicaid service costs (which excludes Health Care Assurance Program (HCAP) and administration), \$14.1 billion was expended on the ABD population, while \$7.0 billion and \$5.5 billion was expended on the CFC and Group VIII populations, respectively.
- The ABD population includes low-income elderly who are age 65 or older, individuals with disabilities, and those who are significantly visually impaired, as well as recipients of the Medicare Premium Assistance Program. The ABD population also includes some individuals who are under age 65 and employed who are disabled, and who are eligible for the Medicaid Buy-In for Workers with Disabilities Program.
- The CFC population consists of low-income children, adults who are age 64 or younger, and pregnant women.
- The Group VIII population includes recipients made newly eligible in 2014 who are age 19 to 64 with incomes at or below 138% of the federal poverty level.
- The cost of long-term care, which is provided primarily to the ABD population, is one of the main reasons for the higher expense associated with this population. Long-term care includes services provided in institutions, such as nursing facilities, or in the home or community through Medicaid waiver programs, such as PASSPORT or Individual Options.
- Each population has its own set of eligibility and income criteria. The modified adjusted gross income is used to determine financial eligibility for the CFC and Group VIII populations. The ABD population must meet both Supplemental Security Income criteria and resource guidelines.

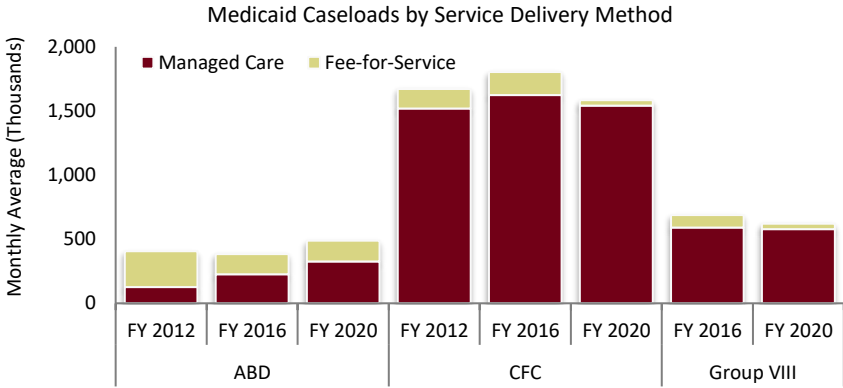
## Medicaid Caseloads Decreased Over the Past Three Years



Source: Ohio Department of Medicaid

- In FY 2020, average caseloads decreased by 1.1% (31,104) to 2.8 million for the year as a whole. However, caseloads began increasing in March due to the COVID-19 pandemic and continued increasing through the end of FY 2020. From the end of February through the end of June, monthly caseload totals grew by 7.1% (about 200,000). Prior to March, monthly caseloads had been steadily decreasing.
- Between FY 2014 and FY 2017, enrollment grew rapidly from 2.5 million to 3.1 million, an increase of 22.8%. These increases were primarily the result of the Medicaid expansion that started in January 2014. Expansion allowed previously ineligible adults between the ages of 19 and 64 with incomes below 138% of the federal poverty level to qualify for coverage (Group VIII).
- Covered families and children (CFC) caseloads experienced an increase in the four-year period after the Great Recession (FY 2011-FY 2014), growing on average 4.1% per year. This is partially due to the addition of family planning services as a limited benefit, which was available from 2012 through 2015. CFC caseloads increased at an average annual rate of 0.1% from FY 2015 to FY 2017. For FY 2018 through FY 2020, caseloads decreased at an average annual rate of 4.4%. However, CFC caseloads did begin increasing in the latter half of FY 2020 due to the COVID-19 pandemic.
- Aged, blind, and disabled (ABD) caseloads also experienced growth following the Great Recession, with caseloads increasing 3.3% on average from FY 2011 to FY 2014. Average annual ABD caseload growth decreased over the following three-year period (FY 2015-FY 2017) at an average annual rate of 0.9%. Following a caseload increase of 13.3% in FY 2018, ABD caseloads largely stabilized, decreasing by 0.3% in FY 2019 and increasing by 1.0% in FY 2020.
- From FY 2000 to FY 2017, total caseloads increased from 1.1 million to 2.8 million. Due to the Great Recession, total caseloads increased by 5.4% in FY 2009 and another 8.4% in FY 2010. Caseloads also increased rapidly in the early 2000s due to the economy and several eligibility expansions for family and children. From FY 2000 to FY 2004, enrollment rose from 1.1 million to 1.7 million, an increase of 46.2%.

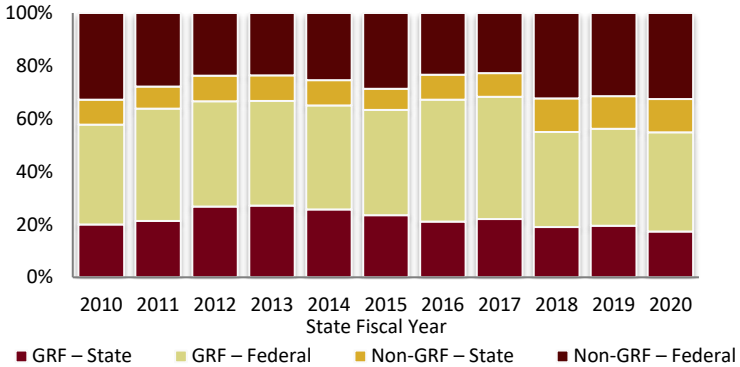
## Managed Care Caseloads Continue to Increase



- Following expansions in Medicaid coverage in FY 2014, Medicaid managed care caseloads increased from 1.6 million in FY 2012 to 2.4 million in FY 2020. As a share of total Medicaid caseloads, the managed care portion increased from 79% in FY 2012 to 91% in FY 2020.
- Under the managed care system, the state pays a fixed monthly premium per enrollee for any health care included in the benefit package, regardless of the amount of services actually used. The fixed monthly premium is required to be actuarially sound. Under the fee-for-service (FFS) system, Medicaid reimburses service providers based on set fees for the specific types of services rendered.
- For the aged, blind, and disabled (ABD) category, managed care caseloads grew from 127,000 in FY 2012 to 326,000 in FY 2020, which increased the proportion of ABD recipients covered by managed care from 31% to 67%. This is due in part to the 2014 implementation of the MyCare Program, a system of managed care plans that coordinate physical, behavioral, and long-term care services for recipients eligible for both Medicaid and Medicare (dual-eligibles).
- For the covered families and children (CFC) category, managed care caseloads stayed relatively consistent with the share covered by managed care increasing slightly from 91% in FY 2012 to 97% in FY 2020.
- Ohio's Medicaid expansion (Group VIII), which was implemented under the federal Affordable Care Act, began providing coverage in January 2014. Group VIII recipients are generally enrolled in managed care, but can receive services through FFS until they select a managed care plan. Between FY 2016 and FY 2020, the proportion enrolled in managed care increased from 86% in FY 2016 to 93% in FY 2020.
- Managed care is now the predominant vehicle by which states provide services to Medicaid recipients. As of July 2019, 40 states had contracts with managed care organizations to provide coverage for at least some of their recipients. Additionally, as of July 2017, over two-thirds of Medicaid recipients received coverage through a managed care plan.

## The GRF Is the Main Funding Source for Ohio Medicaid

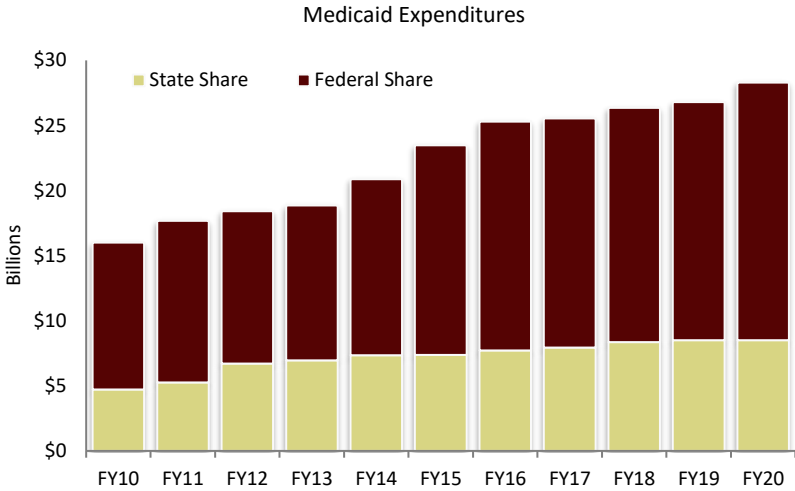
Medicaid Expenditures by Fund Group



Sources: Ohio Department of Medicaid; Ohio Administrative Knowledge System

- Ohio Medicaid is funded by both GRF and non-GRF funds. GRF funds make up the largest share of Medicaid expenditures, accounting for 62.2%, on average, from FY 2010 to FY 2020. Medicaid GRF funds consist of state tax receipts, state nontax receipts, and federal grants. The vast majority of federal grants deposited into the GRF are federal reimbursements for Medicaid.
- While the GRF has historically made up the largest portion of Medicaid funding, the proportion of non-GRF funds has increased over the last three years. State non-GRF funds come from sources such as hospital assessments, health insuring corporation (HIC) franchise fees, and nursing facilities franchise fees. Federal non-GRF funds for Medicaid consist of federal reimbursements for expenditures made with these non-GRF funds.
- While the lowest GRF share of 54.8% was recorded in FY 2020, this share is relatively consistent with the shares for FY 2018 (55.0%) and FY 2019 (56.2%). Prior to these years, the GRF share was typically over 60%. Beginning in FY 2018, there was a shift in expenditures from GRF to non-GRF funds that was largely due to the replacement of the sales tax on Medicaid managed care organizations with a franchise fee on all HICs. The sales tax was deposited into the GRF, whereas the HIC tax is deposited into a non-GRF fund.
- The GRF share increased from 63.3% in FY 2015 to 67.2% in FY 2016 due to an accounting practice change related to Group VIII individuals who became eligible for Ohio Medicaid beginning in January 2014 through the Affordable Care Act expansion. Medicaid expenditures for these individuals were accounted for in non-GRF funds in FY 2014 and FY 2015. However, beginning in FY 2016 funds were accounted for in the GRF.
- Another sizeable shift in shares occurred between FY 2010 and FY 2011, with GRF shares growing from 57.7% to 63.8%. In FY 2010, enhanced federal reimbursements for Medicaid received during the Great Recession were mostly deposited into non-GRF funds. These funds were only available for the first half of FY 2011.

## Medicaid Expenditures Continue to Increase

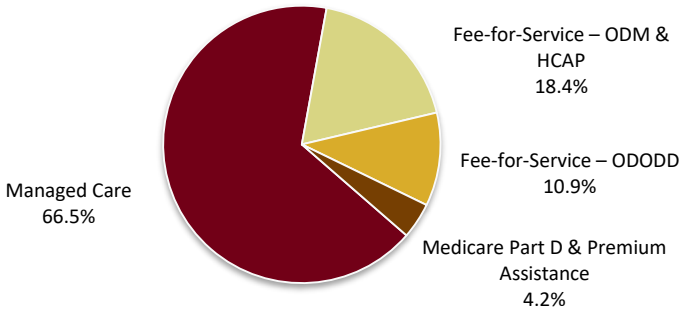


*Source: Ohio Administrative Knowledge System*

- From FY 2010 to FY 2020, Medicaid expenditures increased by more than 175%, growing from \$16.0 billion to \$28.2 billion. The average annual growth rate during this period was 5.9%.
- During the past 11 years, the largest increases in Medicaid expenditures occurred between FY 2013 and FY 2016, with increases of 10.6% from FY 2013 to FY 2014, 12.5% from FY 2014 to FY 2015, and 7.8% from FY 2015 to FY 2016. These increases are primarily due to the expansion in coverage for the Group VIII population, which began in January 2014.
- Medicaid expenditures are affected by policy, economic conditions, the population, and health care prices. Medicaid is countercyclical, so when the economy experiences a downturn enrollment increases and vice versa. This is shown in the chart above. Total Medicaid expenditures grew by smaller amounts from FY 2010 to FY 2013 as the economy gradually expanded after the Great Recession. However, expenditures increased 5.5% from FY 2019 to FY 2020, in response to increased enrollment due to the COVID-19 pandemic.
- The federal government typically reimburses more than 60% of Ohio's Medicaid expenditures. The federal share is determined annually based on the most recent per-capita income for Ohio relative to that of the nation. However, federal reimbursement can be increased during economic downturns. This occurred as a result of the COVID-19 pandemic. The Families First Coronavirus Response Act of 2020 increased federal reimbursements by 6.2 percentage points for certain expenditures made after January 1, 2020 through the end of the COVID-19 emergency.

## Managed Care Comprises Two-Thirds of Total Medicaid Service Expenditures

Medicaid Service Expenditures by Category, FY 2020

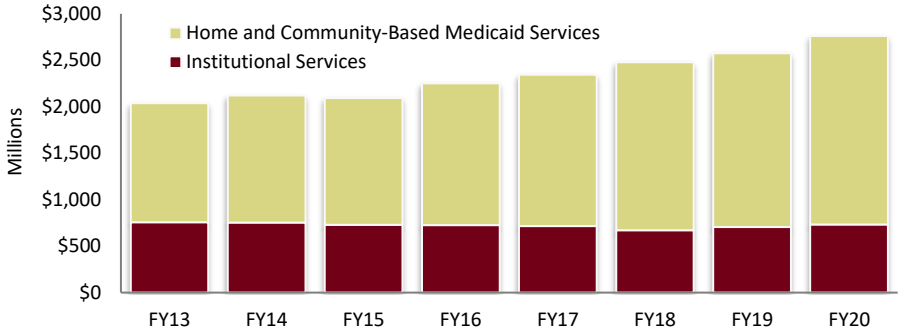


Source: Ohio Administrative Knowledge System

- In FY 2020, Medicaid service (excluding administration) expenditures totaled \$27.3 billion. Managed care comprised the largest share at \$18.1 billion (66.5%). The majority of managed care expenditures are dedicated to the covered families and children (CFC) and Group VIII populations, with spending of \$6.5 billion (23.7%) and \$5.1 billion (18.5%), respectively.
- The remaining managed care expenditures are devoted to three additional Medicaid populations, as well as the Managed Care Pay for Performance Program. The aged, blind, and disabled (ABD) adults had expenditures of \$2.8 billion (10.3%). The MyCare Program (a demonstration program for Medicare/Medicaid dual-eligibles in certain counties) had expenditures of \$2.7 billion (9.7%). The ABD – Kids expenditures were \$961.0 million (3.5%) and the Pay for Performance Program registered expenditures of \$206.1 million (0.8%).
- Fee-for-service (FFS) spending by the Ohio Department of Medicaid (ODM) totaled \$5.0 billion (18.4%) and includes, among others, hospital care, nursing home care, physician services, and pharmacy, as well as expenditures for the Health Care Assurance Program (HCAP). Under HCAP, the state makes subsidy payments to hospitals that provide uncompensated care to low-income and uninsured individuals at or below 100% of the federal poverty level. Expenditures for HCAP were \$660.0 million. FFS services provided by the Ohio Department of Developmental Disabilities (ODODD) totaled \$3.0 billion (10.9%).
- In total, FFS expenditures accounted for \$8.0 billion (29.3%) of Medicaid expenditures. FFS expenditures have decreased in recent years while managed care expenditures have increased, which is due to more recipients receiving coverage through managed care plans.
- The Medicare Part D and Premium Assistance category spending totaled \$1.1 billion (4.2%). This includes expenditures for the following: Medicare Buy-In (\$665.9 million, 2.5%), which assists with premiums and coinsurance payments, as well as Medicare Part D (\$476.7 million, 1.7%), which repays the federal government the amount the state would have spent on Medicaid prescription drugs for dual-eligibles.

## Developmental Disabilities Spending on Home and Community-Based Services Increases

Medicaid Expenditures on Developmental Disabilities



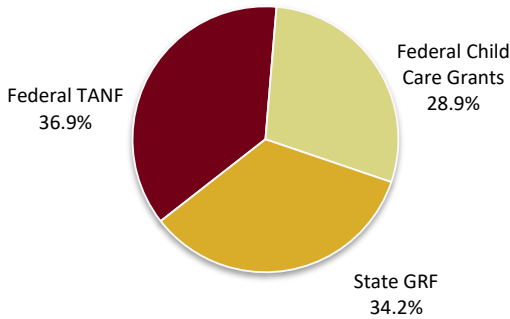
Source: Ohio Department of Developmental Disabilities

- From FY 2013 to FY 2020, Medicaid expenditures for home and community-based services (HCBS) for individuals with developmental disabilities increased by 58.6%, from \$1.3 billion to \$2.0 billion. During this time, expenditures for individuals receiving institutional services decreased by 3.1%, from \$758.2 million to \$734.6 million.
- The Ohio Department of Developmental Disabilities (ODODD) administers three Medicaid HCBS waiver programs that enable individuals with developmental disabilities to remain in their homes or community settings. These programs provide services to increase skills, competencies, and self-reliance to maximize quality of life while ensuring health and safety. Enrollment in ODODD's HCBS waiver programs was roughly 41,300 in FY 2020.
- Institutional services are provided at eight regional developmental centers (DCs) operated by ODODD and at more than 400 intermediate care facilities for individuals with intellectual disabilities (ICFs/IID). Both DCs and ICFs/IID provide health care and habilitative services in a residential setting.
- From FY 2013 to FY 2020, payments to DCs decreased 5.9%, from \$199.8 million to \$188.0 million. Some of this decrease can be attributed to the closure of two DCs (Montgomery and Youngstown) near the end of FY 2017. In FY 2020, there were 607 individuals living in DCs.
- From FY 2013 to FY 2020, payments to ICFs/IID decreased 2.1%, from \$558.4 million to \$546.6 million. ICF/IID enrollment was 4,512 in FY 2020.
- In FY 2020, the average monthly cost of an individual living in a DC was roughly \$25,800. The average monthly cost of an individual residing in an ICF/IID was roughly \$10,100. Average monthly costs for individuals on HCBS waivers are lower than the costs for individuals receiving institutional services. In FY 2020, these costs were approximately \$6,500 for Individual Options Waivers, \$1,100 for Self-Empowered Life Funding Waivers, and \$800 for Level 1 Waivers. Waiver costs vary depending on the level of care an individual needs.



## Majority of Subsidized Child Care Was Funded by Federal Grants in FY 2019

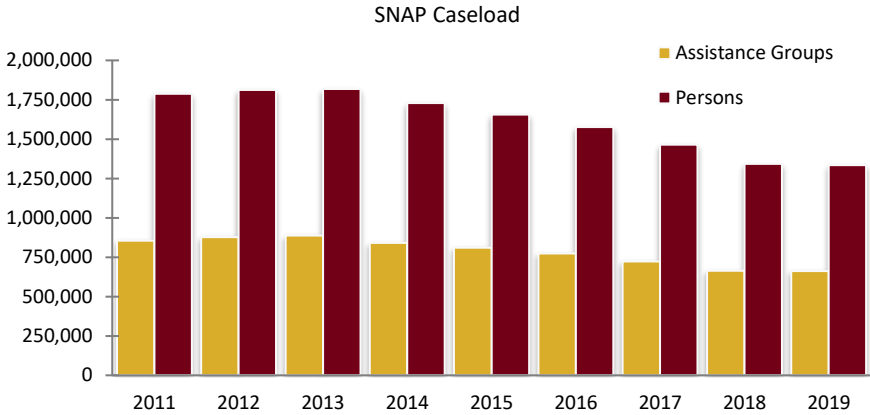
Child Care Expenditures by Funding Source, FY 2019



*Sources: Ohio Department of Job and Family Services; Public Assistance Monthly Statistics*

- Of the \$697.7 million Ohio spent on subsidized child care payments in FY 2019, \$458.9 million (65.8%) was from federal funds. A monthly average of 145,000 children received care, at an average monthly cost of \$402 per child.
- The federal Temporary Assistance for Needy Families (TANF) Block Grant portion totaled \$257.4 million, accounting for 56.1% of federal child care funding and 36.9% of the combined state-federal total. Ohio’s TANF Block Grant is \$726 million per year and is also used for cash assistance and other programs for low-income families.
- Federal Child Care and Development Fund (CCDF) grants accounted for \$201.6 million (28.9%) of the total. There are three separate CCDF grants: a discretionary grant, a mandatory grant, and a matching grant. In addition to direct child care spending, the grants are also used for administration, quality activities (e.g., rating program quality), and other nondirect services.
- State dollars accounted for the remaining \$238.8 million (34.2%), all general revenue funds. Ohio is required by the federal government to annually expend approximately \$84.7 million to receive the CCDF mandatory and matching grants and \$416.8 million to meet the maintenance of effort requirements for TANF. Child care spending makes up a significant portion of the required TANF spending.
- For families enrolled in, or transitioning out of, the Ohio Works First Program, child care is guaranteed. However, for most families, eligibility is based on income level. Families with incomes up to 130% of the federal poverty level (FPL) (\$28,200 for a family of three in 2020) are eligible for initial services if funding is available; families may remain eligible until their incomes rise above 300% FPL (\$65,200 for a family of three in 2020). Families pay copayments to providers on a sliding scale based on income.

## Ohio's Supplemental Nutrition Assistance Program Caseload Drops for the 6<sup>th</sup> Consecutive Year

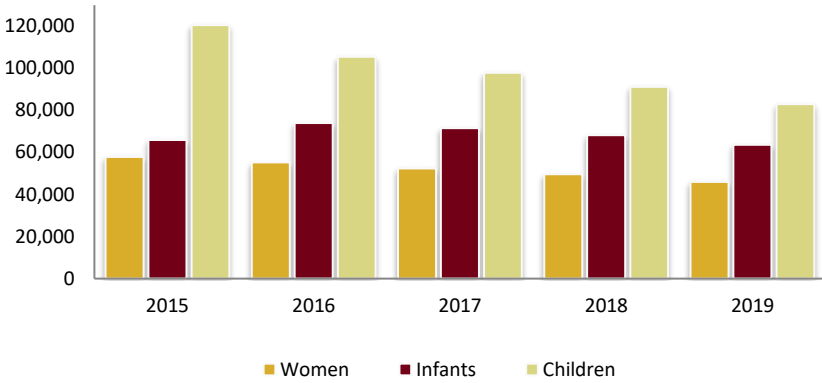


Sources: Ohio Department of Job and Family Services; Public Assistance Monthly Statistics

- The federal Supplemental Nutrition Assistance Program (SNAP) has seen a drop in the number of people and assistance groups receiving benefits in Ohio since 2013. In 2013, Ohio had an average monthly caseload of 1.82 million individuals in 888,000 assistance groups. By 2019, this decreased to 1.33 million individuals in 663,000 assistance groups.
- In 2019, Ohio disbursed \$2.01 billion in SNAP benefits, with an average benefit of \$126 per recipient per month. Benefits are paid entirely by the federal government and are transmitted directly to the processor Ohio contracts with to distribute benefits. These funds are not part of the state treasury and are therefore not appropriated by the General Assembly.
- Determinations for SNAP benefits are made by county departments of job and family services. The federal government reimburses state and local administration costs at a rate of 50%.
- To qualify for benefits, recipients must earn less than 130% of the federal poverty level (\$28,200 annually for an assistance group of three in 2020). The benefit amount varies based on the income and size of the assistance group.
- An assistance group's monthly benefit is automatically loaded onto their Ohio Direction Card, which can be used like a debit card to purchase eligible food items. Most grocery stores accept the Ohio Direction Card.
- SNAP is a United States Department of Agriculture/Food and Nutrition Service program that assists low-income households to purchase food from authorized merchants. A household that receives benefits under the program is a group of people who purchase and prepare meals together. This would generally be a family, but may also include unrelated adults who share a home and meals.

## Ohio’s Participation in the Special Supplemental Nutrition Program for Women, Infants, and Children Declining

Ohio WIC Participation FFY 2015-FFY 2019



Source: United States Department of Agriculture, Food and Nutrition Service<sup>1</sup>

- Ohio’s participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has declined over the past five years. Between federal fiscal year (FFY) 2015 and FFY 2019, the total average number of participants decreased from about 244,000 to 193,000, a reduction of 21.1%. The number of children participating in the program experienced the largest decline falling from about 120,000 to 83,000 (31.2%). The decrease is likely tied to economic conditions and a reduction in the number of births.
- WIC provides nutritious foods, nutrition and breastfeeding education and support, and health care referrals to eligible individuals. It serves approximately half of all babies born in the U.S. and is 100% funded by the federal government.
- With the decline in participation, food costs and monthly benefits have also decreased from 2015 to 2019. During this period, the overall food costs decreased from \$101.8 million to \$72.0 million (29.3%), while the average monthly benefit per person fell from \$34.76 to \$31.16 (10.4%). These amounts do not include WIC Farmers’ Market vouchers, which are given to participants to purchase produce at authorized markets and farm stands.
- To qualify for WIC, an individual must be a pregnant, postpartum, or breastfeeding woman; an infant or a child up to five years of age; be at medical or nutritional risk; and have an income up to 185% of the federal poverty level (\$40,200 for a family of three in 2020).
- WIC is not meant to provide all foods necessary for a family. Instead, it provides for specific types of foods that tend to be lacking in the diets of low-income women and young children. Examples of foods provided through WIC include whole grain bread, cereal, baby food, eggs, iron-fortified infant formula, and milk.

<sup>1</sup> Data for 2017 through 2019 are preliminary.

## Ohio's Percentage of Preterm Births and Infant Mortality Rate Exceed National Statistics

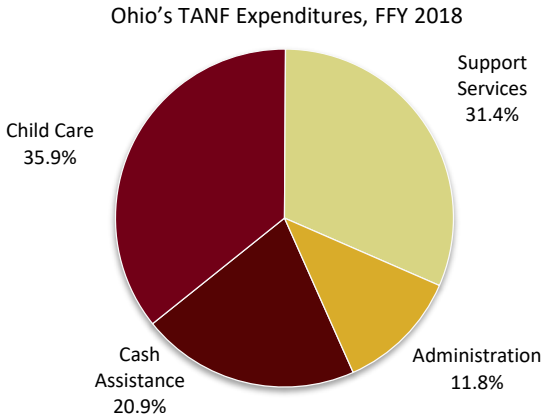
### Ohio and United States Population Statistics, 2017

Category	Ohio	United States
<b>% of Preterm Births</b>	<b>10.4%</b>	<b>9.9%</b>
Non-Hispanic White	9.4%	9.1%
Non-Hispanic Black	14.6%	13.9%
Hispanic	11.0%	9.6%
<b>Infant Mortality Rate</b>	<b>7.2</b>	<b>5.8</b>
Non-Hispanic White	5.3	4.6
Non-Hispanic Black	15.9	11.5
Hispanic	7.2	5.4

*Sources: Kaiser Family Foundation; Centers for Disease Control and Prevention*

- In 2017, 10.4% of all births in Ohio were preterm births (less than 37 weeks of gestation) compared to the national average of 9.9%. Similar to the national pattern, the percentage of preterm births in Ohio for non-Hispanic black infants (14.6%) was higher than the percentage for both non-Hispanic white (9.4%) and Hispanic (11.0%) infants.
- In 2017, there were a total of 14,168 preterm births in Ohio. Preterm birth makes infants more vulnerable to developmental delays and both short-term and long-term medical problems. In 2014, the average health care cost in the first year of life for a premature infant was about \$55,400 as compared to \$5,100 for a full-term, healthy infant.
- Factors that increase the risk of preterm birth include: having a previous preterm birth or a chronic medical condition, sustaining a physical injury, being very overweight or underweight before pregnancy, smoking or substance use, and having a birth interval shorter than 18 months.
- During 2017, Ohio's overall infant mortality rate of 7.2 (infant deaths per 1,000 live births) was higher than the national rate of 5.8. The rate for non-Hispanic blacks in Ohio and in the United States was more than twice the rate for non-Hispanic white infants.
- The leading causes of infant mortality are preterm birth, low birth weight, congenital anomalies, sudden infant death syndrome, maternal pregnancy complications, and injury, such as accidental rollover or suffocation.

## Child Care Accounted for Over a Third of Ohio’s TANF Expenditures in Federal Fiscal Year 2018

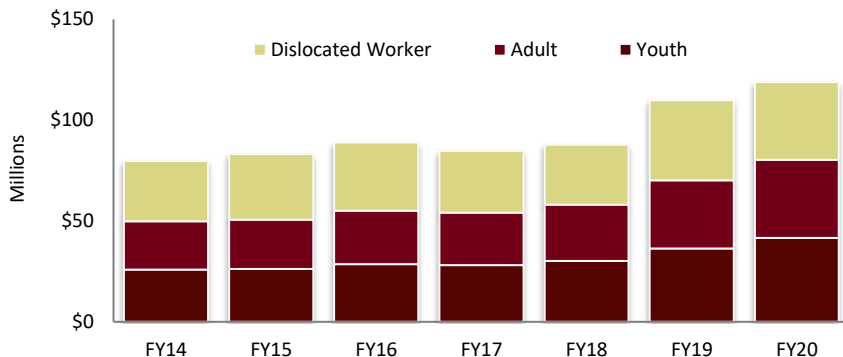


*Source: U.S. Department of Health and Human Services*

- In federal fiscal year (FFY) 2018, subsidized child care accounted for \$405.9 million (35.9%) of Ohio’s \$1.13 billion in total Temporary Assistance for Needy Families (TANF) expenditures. Subsidized child care is available to children in families with incomes up to 130% of the federal poverty level (FPL). An average of 145,000 children received subsidized child care each month in state fiscal year 2019. In addition to TANF dollars, other state and federal funds are also used to pay child care providers.
- Cash assistance payments provided under the Ohio Works First (OWF) Program accounted for \$236.8 million (20.9%) of total TANF expenditures. In state fiscal year 2019, an average of 50,000 assistance groups per month received OWF benefits with an average benefit of \$210 per recipient.
- OWF assistance groups must include a minor child or pregnant woman and have income of no more than 50% of the FPL. Heads-of-household must sign a self-sufficiency contract that includes a work plan. Benefits are limited to 36 consecutive months (with a lifetime limit of 60 months), but time and income limits and work requirements do not apply to “child-only” cases, in which a relative caregiver receives the benefit on behalf of a child.
- Support services (\$355.9 million, 31.4%) are short-term noncash benefits provided at the local level and may include shelter, job-required clothing, household necessities, transportation, and other services allowable under federal law. Administration (\$133.6 million, 11.8%) includes both state and local activities such as eligibility determination and case management.
- Ohio’s TANF resources total about \$1.14 billion each year: \$726 million from the federal TANF Block Grant and \$417 million in state funds to meet the TANF maintenance of effort requirement.

## Ohio's Federal Workforce Innovation and Opportunity Act Grants Increased Since FY 2014

Ohio's Federal WIOA Allocations

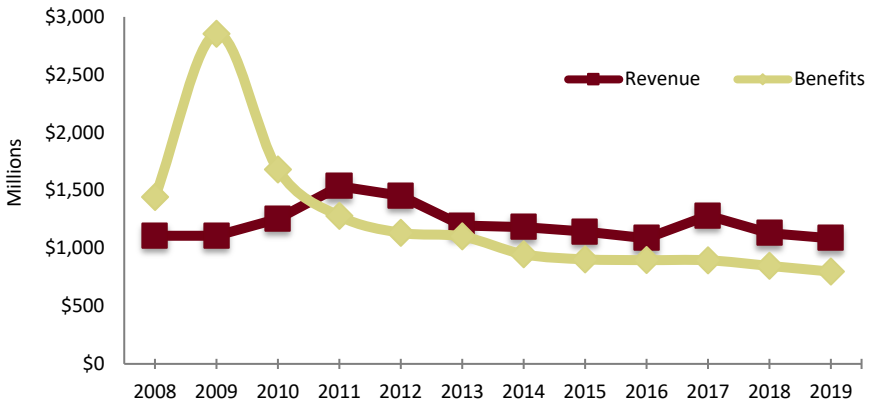


Sources: U.S. Department of Labor; Federal Funds Information for States; ODJFS

- Ohio's federal Workforce Innovation and Opportunity Act (WIOA) grants increased from \$79.8 million in FY 2014 to \$119.0 million in FY 2020, an increase of 49.2%. Grants were fairly stable between FY 2014 and FY 2018, but increased by 25.0% between FY 2018 and FY 2019 going from \$87.9 million to \$109.8 million.
- Ohio's WIOA grants in FY 2020 totaled \$119.0 million, including \$41.6 million for youth, \$38.8 million for adults, and \$38.6 million for dislocated workers.
- WIOA grants are largely distributed based in part on each state's share of the total unemployed and economically disadvantaged nationwide.
- WIOA is administered at the state level by the Ohio Department of Job and Family Services (ODJFS) and locally by 20 regional workforce investment boards. Service delivery is provided by 88 local OhioMeansJobs (One-Stop) centers, with one center in each county.
- ODJFS is required to distribute 85% of the state's total annual WIOA grants to Ohio's workforce investment boards for service delivery. The remaining WIOA dollars are used by ODJFS to help areas in the state that experience mass layoffs, for administration, and other statewide workforce programs.
- Statewide WIOA activities include support for OhioMeansJobs.com, a statewide job posting board that is free for employers and job seekers.
- Youth dollars are used at the local level to support the Comprehensive Case Management and Employment Program (CCMEP), which establishes pathways to employment for individuals aged 14 to 24 using both WIOA and Temporary Assistance for Needy Families funds.
- In addition to its regular WIOA grants, Ohio can receive Dislocated Worker Grants to respond to large, unexpected, numbers of dislocated workers due to layoffs, international trade effects, and natural disasters.

## Ohio’s Unemployment Compensation Revenues Exceeded Benefit Payments the Last Nine Years

UC State Revenues and Regular Benefits



Source: Ohio Department of Job and Family Services, Ohio Labor Market Information

- The state’s regular unemployment compensation (UC) revenues have exceeded benefits every calendar year from 2011 through 2019. In 2019, UC revenues totaled \$1.09 billion, \$288.1 million higher than net benefit payments of \$797.8 million.
- Regular state UC revenue is derived from taxes paid by most Ohio employers on the first \$9,000 of each employee’s wages. Rates are set in state law and are based on an employer’s “experience” of unemployment. In 2019, tax rates ranged from 0.3% to 9.0% and averaged about 2.2%, or \$209 per employee (based on a taxable wage base of \$9,500). The taxable wage base was temporarily increased for calendar years 2018 and 2019 by S.B. 235 of the 131<sup>st</sup> General Assembly.
- State law classifies employers as either “contributory” or “reimbursing.” Most employers are contributory and pay UC taxes on a quarterly basis. Reimbursing employers, which are mostly government entities, reimburse the UC Fund for the exact cost of the benefits.
- Generally, contribution rates are lower for employers that have paid taxes for several years with few layoffs and higher for newer employers and those with frequent layoffs.
- Recipients of UC are eligible to receive amounts equal to half their employed wages up to a maximum amount that is adjusted annually based on the statewide average weekly wage. At the end of 2019, the average recipient received \$384 weekly for 14.0 weeks.
- After depleting the Unemployment Compensation Fund in January 2009, Ohio borrowed \$3.39 billion from the federal government to continue paying benefits. The remaining balance of this federal debt was paid in August 2016. Through 2019 Ohio has not borrowed additional amounts.

## Workers' Compensation Claims and Benefits Continued to Decline in 2019

### Workers' Compensation Benefits and Claims Paid from the State Insurance Fund

	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
<b>Benefits (\$ in millions)</b>					
Medical	\$614.4	\$580.3	\$550.6	\$526.4	\$490.0
Lost Time	\$1,033.1	\$1,021.6	\$940.8	\$937.0	\$916.7
<b>Total</b>	<b>\$1,647.4</b>	<b>\$1,601.9</b>	<b>\$1,491.4</b>	<b>\$1,463.4</b>	<b>\$1,406.8</b>
<b>Number of New Allowed Claims</b>					
Total	93,936	88,170	86,290	85,136	84,364
<b>Number of Open Claims</b>					
Total	791,638	752,312	704,756	672,188	646,379

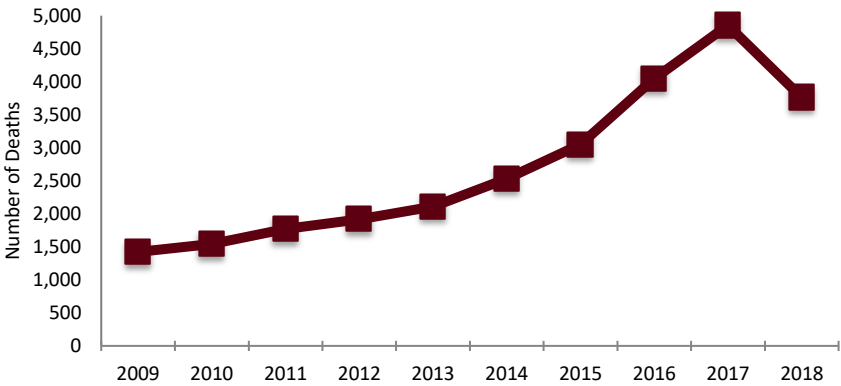
*Source: Ohio Bureau of Workers' Compensation*

- Total benefits paid by the Bureau of Workers' Compensation (BWC) for lost time and medical claims have declined steadily between FY 2015 and FY 2019. In FY 2019, lost time and medical benefits paid totaled \$1.41 billion, an amount \$240.7 million (14.6%) lower than the \$1.65 billion of total benefits paid in FY 2015.
- In FY 2019, medical claims dropped to \$490.0 million from \$614.4 million in FY 2015, a decrease of \$124.4 million (20.2%). Lost-time benefits declined to \$916.7 million in FY 2019 from \$1,033.1 million in FY 2015, a decline of \$116.4 million (11.3%).
- The number of claims, both new and open, have dropped steadily in each year during the five-year period. Between FY 2015 and FY 2019, new allowed claims dropped by 10.2% and open claims dropped by 18.3%.
- Of the 646,379 open claims in FY 2019, 207,594 were related to lost time while the remaining 438,785 were medical-only claims.
- In FY 2019, BWC provided coverage to 249,472 employers, including 3,911 state and local public employers and a total of 1,160 employers qualified to self-insure. Premiums and administrative assessments collected from BWC-insured employers totaled \$1.29 billion in FY 2019.
- As of June 30, 2019, BWC had \$29.37 billion in total assets, an increase of \$490.9 million (1.7%) relative to total assets at the end of FY 2018. Net assets (assets minus liabilities) totaled about \$11.30 billion, an increase of \$1.37 billion (13.8%) compared to the corresponding measure at the close of FY 2018.



## Unintentional Overdose Deaths in Ohio Fell for the First Time in Ten Years in 2018

Unintentional Drug Overdose Deaths in Ohio



*Source: Ohio Department of Health*

- Between 2009 and 2017, the number of unintentional drug overdose deaths increased each year, rising from 1,423 to 4,854, (241.1%). In 2018, the number of deaths decreased to 3,764, a reduction of 22.5% from 2017. The death rate per 100,000 population (age-adjusted) during these years rose from 12.7 in 2009 to 44.1 in 2017 before finally falling to 34.1 in 2018.
- Between 2017 and 2018, both the number of overdose deaths and the death rates decreased for all sex and race/ethnicity groups. In 2018, white non-Hispanic males contributed to the largest number of deaths with 2,062 deaths (death rate of 48.1). However, black non-Hispanic males experienced the largest death rate of 49.5 (357 total deaths). Overall, males had a much higher death rate (45.8) than females (22.7).
- Between 2017 and 2018, the number of overdose deaths decreased for all age groups. In 2018, among all age groups, individuals aged 25 to 34 contributed to the largest total number of deaths with 1,063 (death rate of 68.8). However, individuals aged 35 to 44 had the highest death rate of 75.8 (1,054 total deaths). Four individuals under age 15 died from an overdose in 2018. Otherwise, individuals aged 65 and over had the fewest number of deaths (122) and the lowest death rate (6.1).
- In 2018, the three largest counties made up about one-third of all overdose deaths. Franklin County had the highest number with 476 deaths, followed by Cuyahoga County with 443, and Hamilton County with 357. However, in terms of death rates, Scioto County had the highest rate of 68.3 (47 deaths) followed by Brown County with 65.7 (26 deaths), and Meigs County with 62.9 (14 deaths). In comparison, the three largest counties had rates of 35.6, 35.5, and 45.1, respectively.
- Illicit fentanyl or analogs were involved in 72.6% of overdose deaths in 2018, often in combination with other drugs. Fentanyl is a synthetic opioid similar to morphine, but 50 to 100 times stronger, that is used to treat extreme pain.