**Budget Policy**

**May 7, 2015**



**Testimony to Senate Subcommittee on Medicaid**

**On the 2016-17 budget bill**

Wendy Patton

Good morning, Chairman Burke and members of the committee. My name is Wendy Patton and I am a Senior Project Director at Policy Matters Ohio, a nonprofit, nonpartisan organization with the mission of creating a more prosperous, equitable, sustainable and inclusive Ohio. Thank you for the opportunity to testify today regarding the budget for fiscal years 2016-17.

In 2013, the Kasich Administration made the smart and compassionate choice of expanding Medicaid to low-income Ohioans earning less than 138 percent of poverty, or about $22,000 for a mother with one child. A half million Ohioans enrolled in the first year.[[1]](#footnote-1) Hospitals and health care systems saw their bottom lines strengthen.[[2]](#footnote-2) By taking advantage of flexibility in the Medicaid program, the state is reducing costs.[[3]](#footnote-3)

Changes in the state Medicaid program proposed in the House budget bill, ostensibly to teach responsibility and to encourage work, will instead act as barriers to needed health care, defeating the promise of health care reform.

* **Medicaid expansion enrollees are working:** According to Director McCarthy, half of those enrolled through the Medicaid expansion do work, or were enrolled in a separate waiver program.[[4]](#footnote-4)
* **Among those who are not working, most have health problems that could affect ability to work.** Director McCarthy’s presentation showed that close to half of expansion enrollees without income had a history of behavioral health treatment (42 percent) and/or chronic illness other than behavioral health (69 percent). [[5]](#footnote-5)

The House budget’s “Healthy Ohio” program would dismantle the promising program the State has in place at present and erect barriers to care:[[6]](#footnote-6)

* **Costly for individuals and families:** The house program would impose premium payments (in addition to existing co-pays) not just on the men and women enrolled through Medicaid expansion, but on families and children. Forty years of research has proven that imposing costs on health care reduces use by poor families. This is because they have limited income. They chose between gas, car repairs, food, babysitter, rent, and other bills. Health care falls to the bottom of the pile.[[7]](#footnote-7)
* **Costly for the state:** Assignment and tracking of care and payments have been expensive in other states.[[8]](#footnote-8)
* **Interrupted care:** The plan in the House budget would suspend care for a full year for missed payments or paperwork. A 12-month interruption in care for cancer, migraines or other conditions is harmful and limits ability to work.
* **Administrative complexity**: Ostensibly, monthly payments would help patients adjust to the private market. However, payments would be translated into “points,” not dollars, different from real-world transactions.
* **Unfair:** Those who have bank accounts and arrange electronic funds transfer would be given extra health care “points,” but many patients have no bank account.[[9]](#footnote-9) Poor families lack consistent income. Temporary jobs start and stop. Retail hours rise and fall with seasonal demand.[[10]](#footnote-10) These families are less likely to use electronic funds transfer because of irregular employment or low income.
* **Wait time:** Beneficiaries could be forced to wait days or months for care. Before getting care, patients would need to submit an application, have the account created, make an initial payment, and establish “points”.
* **Caps on care:** Coverage is suspended if the cost of care exceeds the $300,000 annual cap or the $1,000,000 lifetime cap. Annual suspensions last until the next year of coverage. The plan calls for a catastrophic health care plan for those who exceed annual or lifetime caps, but there is no indication of how this would be financed or of the impact on continuity of care for sick patients.

The federal government has certain smart requirements that are part of the Medicaid program. States can’t drop poverty-level patients if they don’t pay premiums, charge people more than Medicaid rules allow, force patients to work or hunt for a job, or limit certain Medicaid benefits. These rules help make sure people actually get care, which is the fundamental goal of the expansion. Much of what the House proposes would not be accepted under a federal Medicaid waiver.

Ultimately, national health care reform is about better health for all Americans – including those with moderate and low incomes – and strengthening the health care system that serves all Americans. Ohio’s Medicaid expansion plan is doing well. Ohio should stay the course.

 *Policy Matters Ohio is a nonprofit, non-partisan research institute*

*with offices in Cleveland and Columbus.*

1. Ohio Department of Medicaid caseload reports at http://medicaid.ohio.gov/RESOURCES/ReportsandResearch/CaseloadReports.aspx [↑](#footnote-ref-1)
2. Wendy Patton, Financial requirements prevent Medicaid patients from getting needed care, Policy Matters Ohio, February 16, 2015 at http://www.policymattersohio.org/medicaid-feb2015 [↑](#footnote-ref-2)
3. John McCarthy, Medicaid Director, “Ohio Department of Medicaid: SFY 2016-17 budget priorities, presentation to the senate subcommittee on Medicaid, May 5, 2015 at http://www.ohiosenate.gov/committee/medicaid# [↑](#footnote-ref-3)
4. *Id.* [↑](#footnote-ref-4)
5. *Id.* [↑](#footnote-ref-5)
6. These points are taken from Wendy Patton, Ohio House moves Medicaid in the wrong direction, April 23, 2015 at http://www.policymattersohio.org/medicaid-april2015 [↑](#footnote-ref-6)
7. Wendy Patton, “Financial requirements prevent Medicaid patients from getting needed care, February 16, 2015 at http://www.policymattersohio.org/medicaid-feb2015 [↑](#footnote-ref-7)
8. Virginia Department of Medical Assistance Services memo, (May 15, 2002); see also, L. Summer & C. Mann, “Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies,” The Commonwealth Fund (June 2006). Cited in Tricia Brooks, Handle with Care: How Premiums Are Administered in Medicaid, CHIP and the Marketplace Matters, Georgetown University Center for Families and Children at <http://www.healthreformgps.org/wp-content/uploads/Handle-with-Care-How-Premiums-Are-Administered.pdf>, cited in Patton, “Financial requirements prevent Medicaid patients from getting needed care,” *Op.Cit.* [↑](#footnote-ref-8)
9. In 2009 Cleveland was the fourth most “unbanked” large city in the nation: 17 percent of households had no bank account.In 2011, 8.8 percent of all Ohio households (414,000 households) were unbanked. This is higher than the national average of 8.2 percent and grew by 95,000 households – 30 percent – between 2009 and 2011.Medicaid expansion will serve many of these same households. See The most unbanked places in America, Corporation for Enterprise Development at <http://cfed.org/assets/pdfs/Most_Unbanked_Places_in_America.pdf> ; 2011 FDIC National Survey of Banked and Underbanked Households, Appendix H, Table H-1 2011 Household Banking Status by State <https://www.fdic.gov/householdsurvey> [↑](#footnote-ref-9)
10. [↑](#footnote-ref-10)