Policy Matters Ohio

Medicaid

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Testimony to Medical Care Advisory Committee on proposed "Healthy Ohio" plan

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Good morning, Director McCarthy and members of the committee. My name is Wendy Patton and I am with 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 state's proposal for the "Healthy Ohio Plan."

Medicaid provides health insurance for people less than 65 years old who lack health care through their employer and cannot afford private insurance. As of March 2016, a quarter of all Ohioans were insured through Medicaid. Medicaid expansion has allowed hundreds of thousands of Ohioans who were previously uninsured and lacked affordable coverage options, to see a doctor.

Access to health care lets people see a doctor regularly and prevent illness and crisis. Preventive care, like cancer screenings and check-ups, enables illnesses to be caught and treated early, which can save costs, dramatically reduce suffering and boost opportunity for a healthy and productive life. Access to care reduces the spread of infectious disease, helping everyone in our communities, including people with private coverage. Insurance and regular care can prevent financial crisis and reduce financial burdens that people with chronic illness face. Uninsured patients who face a medical crisis are disproportionately likely to end up in bankruptcy or foreclosure.[1] Insurance coverage through Medicaid helps prevent these financial disasters.

The "Healthy Ohio Plan" proposal asks the U.S. Secretary of Health and Human Services to waive certain Medicaid rules for non-elderly adults - about half of the Medicaid enrollment - and allow different rules. Medicaid rules may be waived under Section 1115 of the Social Security Act, which allows approval of demonstration projects that promote the objectives of Medicaid programs. Demonstration projects are supposed to increase and strengthen overall coverage of the low-income population; increase access to, stabilize, and strengthen providers and provider networks serving Medicaid enrollees; improve health outcomes and increase the efficiency and quality of care for people insured by Medicaid.

The "Healthy Ohio Plan" does not further these objectives and it should not be approved as another demonstration project. Ways in which it hinders these objectives are outlined in our testimony.

[1] Christpher T. Robertson et. Al., "Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures" Health Matrix: Journal of Law-Medicine, Vol. 18, No. 65, 2008

1. The "Healthy Ohio Plan" would not increase and strengthen overall coverage of low-income individuals. In fact, it would reduce such coverage.

The Department of Medicaid's analysis forecasts a decline in Medicaid enrollment among the non-elderly adult population of 8.9 percent if the Healthy Ohio waiver is in place, compared to similar assumptions about market penetration but without the proposed waiver. These people would have nowhere else to turn for health coverage; they likely would not have an offer of coverage through their employer and their income would be too low for subsidies to purchase marketplace coverage.

2. The "Healthy Ohio Plan" does not increase access to health care by low-income populations. It reduces it. It could also financially harm Medicaid providers.

Fewer adults would enroll in the Ohio's Medicaid program under the program rules proposed in the "Healthy Ohio Plan". The proposal posted on April 15 forecast that 126,000 and 140,000 individuals would lose Medicaid coverage in each of the five years of the demonstration period.[2] The new rules would impose hardship and people would either drop out of the program or choose not to enroll.

The "Healthy Ohio Plan" will require premiums of up to 2 percent of annual adjusted income for non-elderly adults, up to $99 a year or $8.25 per month. This sounds small, but for people on very limited incomes – like those on Medicaid – such costs have been found to decrease use of health care services. The U.S. Department of Health and Human Services published research in July 2015 that found increased costs make it harder for poor families to access needed health care and maintain coverage. Key findings include:[3]

- Low-income individuals are especially sensitive to increases in medical costs. Modest co-payments can have the effect of reducing access to necessary medical care.
- Medical fees, premiums, and co-payments could contribute to the financial burden on poor adults who need to visit medical providers.
- The problem is even more pronounced for families living in the deepest levels of poverty, who effectively have no money available to cover out-of-pocket medical expenses, including co-pays for medical visits.

The Rand Corporation's Health Insurance Experiment, published in 1982, was a long-term, experimental study of cost sharing. The study found provision of health care without cost improved hypertension, dental health, vision, and selected serious symptoms among the sickest and poorest patients.[4] A recent study published in the *Journal of Health Economics* found that among the poorest Medicaid enrollees – those earning less than 150 percent of the federal poverty level – a monthly premium of up to $10 results in fewer months of continuous

[2] Ohio Department of Medicaid, "Healthy Ohio Program 1115 Demonstration Waiver," (Appendix 1) at http://medicaid.ohio.gov/Portals/0/Resources/PublicNotices/HealthyOhio-Detail.pd
[3] Office of the Assistant Secretary for Planning and Evaluation, "Financial Condition and Health Care Burdens of People in Deep Poverty," United States Department of Health and Human Services, July 16, 2015
[4]Robert H. Brook et.al., "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate," http://www.rand.org/pubs/research_briefs/RB9174.html

enrollment for adults and children. These effects are concentrated in the first few months of coverage: enrollees are 12 to 15 percent more likely to leave the program within 12 months.[5] Here in Ohio, MetroHealth Hospital's early experiment with Medicaid expansion had similar findings: The expansion of readily accessible care, without cost, enhanced health.[6]

Research over many years shows that imposing costs on health care reduces use by poor families or results in discontinuous use. This is because they have limited income. They chose between gas, food, rent, and other bills. Health care falls to the bottom of the pile.

The "Healthy Ohio Plan" lock-out provision will reduce access to care. If someone misses two monthly payments or a paperwork deadline, he loses coverage. If he lost coverage because he couldn't pay the premium, he must repay what he owed for prior months before regaining care. This makes regaining access more difficult.

People losing their health coverage will hurt the providers who would otherwise serve them, or do serve them but are not compensated for the care they provide. For example, if someone who has not enrolled in Medicaid because of the premium breaks a leg, Medicaid coverage will not start until the first premium is paid, so the provider who sets that leg is not paid. If the patient has been locked out of Medicaid coverage, she is even less likely to be able to cover both unpaid premiums and a re-enrollment premium. A physician or hospital will serve her, but without insurance. Growth of uncompensated care undermines an Ohio health care system that has been strengthened by insurance coverage afforded by the Medicaid expansion.

3. The "Healthy Ohio Plan" will not result in improved health outcomes.

The Plan will cause a spike in uninsurance, narrowing access and fostering poor health outcomes for low-income populations. The low-income population has especially pressing needs for continuous access to health care. Poverty increases likelihood of chronic diseases like diabetes, hypertension and depression.[7] Continuity of care matters in managing these diseases.[8] Barriers that interrupt consistent, ongoing care result in poor health outcomes.

The Health Savings Account model upon which the "Healthy Ohio Plan" is based is inappropriate, because savings are premised on reduced use of health care services. The health care problem of many poor people is **underuse** of medical services.[9] The conservative Rand

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[5] Laura Dague, "The effect of Medicaid premiums on enrollment: A regression discontinuity approach," Journal of Health Economics 37 (2014) 1-12.

[6] Randall D. Cebul, Thomas E. Love, Douglas Einstadter, Alice S. Petrulis and John R. Corlett, "MetroHealth Care Plus: Effects Of A Prepared Safety Net On Quality Of Care In A Medicaid Expansion Population,".Health Affairs, July 2015 vol. 34 no. 7 1121-1130 at http://content.healthaffairs.org/content/34/7/1121.abstract

[7] The World Health Organization, "Chronic Disease and Health Promotion, Chapter two – Chronic Diseases and Poverty" at http://www.who.int/chp/chronic_disease_report/part2_ch2/en/

[8] "The Role of Medicaid for adults with chronic illnesses," Kaiser Family Foundation, November 2012 at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383.pdf

[9] Americans are much more likely than their counterparts in other countries to say they did not visit a physician, fill a prescription, or get a recommended test, treatment, or follow-up care because of costs. In a comparison among developed nations, disparities in care between people in above-average and below-average income groups were greatest in the United States. Karen Davis, Cathy Schoen, Stephen C. Schoenbaum, Anne-Marie Audet, Michelle

Corporation, reviewing studies on the effect of high deductible health plans coupled with Health Savings Accounts, concluded: "While evidence suggests that the health of the overall population may not change with increased cost sharing, the health of individuals with low income and greater health care needs may decline."[10]

4. The "Healthy Ohio Plan" will not increase the efficiency and quality of care for the low-income population. It will make it less efficient and reduce care quality.

Healthy Ohio will actually make Medicaid *less* efficient. Per member, per month costs increase. The proposal contains several so-called "incentives" that are identified as innovative service delivery features intended to improve health outcomes or administrative efficiency, but would likely be unattainable for many enrollees. They are not likely to increase efficiency or quality of care uniformly across low-income populations.

Incentive points that allow increased access to health care are given for certain activities. These features could discriminate against low-income families:

- The neighborhoods in which low-income populations live may offer neither healthy food nor opportunities for exercise that would allow enrollees to garner incentive points in their modified health savings accounts.
- The low-wage labor market has uncertain hours and erratic schedules, posing barriers to attendance of health classes at set times.
- Incentive points are given to enrollees with bank accounts who arrange electronic funds transfers for premium payment. Ohio has many unbanked families who cannot participate in this incentive.[11] Cleveland ranks as one of the most unbanked large cities in the nation.[12]
- Lack of transportation has been identified as a leading problem for the low-income population in Ohio.[13] People who struggle to get to work will face the same obstacles in getting to smoking cessation or other health improvement classes.
- Parents with children are included in the "Healthy Ohio Plan." Expecting them to attend health care classes is unrealistic in many cases.

The effectiveness of incentives in health care delivery has been questioned because of high costs of infrastructure start-up, marketing, and administration. Evaluations have identified specific problems that prevented attainment of health goals or reduced care for some beneficiaries.[14] The

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Doty, and Katie Tenney, *Mirror Mirror on the Wall: The Quality of American Health Care Through the Patients' Lens*, The Commonwealth Fund, October 2003.

[10] "Analysis of High Deductible Health Plans," RAND corporation at http://www.rand.org/pubs/technical_reports/TR562z4/analysis-of-high-deductible-health-plans.html#health

[11] Federal Deposit Insurance Corporation, 2013 National Survey of Unbanked and Under-banked Households at https://www.fdic.gov/householdsurvey/

[12] Corporation for Enterprise Development, https://cfed.org/assets/pdfs/Most_Unbanked_Places_in_America.pdf

[13] Workgroup to reduce reliance on public assistance: Report to Governor John Kasich and the Ohio general Assembly, April 15, 2015 at http://humanservices.ohio.gov/WorkArea/DownloadAsset.aspx?id=2147636202

[14] Kaiser Family Foundation issue brief (https://kaiserfamilyfoundation.files.wordpress.com/2014/09/8631-an-overview- of-medicaid-incentives-for-the-prevention-of-chronic-diseases-mipcd-grants.pdf); see also Judith Solomon, West Virginia's Medicaid Changes Unlikely to Reduce State Costs or Improve Beneficiaries' Health (Washington, DC: Center on Budget and Policy Priorities, May 2006) http://www.cbpp.org/cms/?fa=view&id=336. Also see Wisconsin Department of Health Services. "Do Incentives Work for Medicaid Members? A Study of Six Pilot Projects." May 2013. Available at: http://www.dhs.wisconsin.gov/publications/p0/p00499.pdf.

evaluation metrics of the "Healthy Ohio Plan" proposal are not gauged to identify which groups of people will be helped or hurt by the incentives of the Plan. There will be no way to know who is helped or hurt and whether it offers positive models for other Medicaid programs.

Thank you for allowing me to testify on this proposal. I am happy to answer any questions that you may have.

Policy Matters Ohio is a nonprofit, non-partisan research institute with offices in Cleveland and Columbus.