Policy Matters Ohio

Medicaid

July 2016

July 28, 2016

VIA ELECTRONIC SUBMISSION

Sylvia Matthews Burwell, Secretary
Health and Human Services
200 Independence Avenue. S. W.
Washington, D.C. 20201

Submitted online at Medicaid.gov

RE: Comments in Opposition to 1115 Demonstration Waiver

Policy Matters Ohio is a not-for-profit, non-partisan research organization with a mission of creating a more vibrant, equitable, inclusive and sustainable Ohio through research and policy work. We appreciate the opportunity to provide comments on Ohio's proposed § 1115 demonstration project, the 'Healthy Ohio' plan.

The proposal would reverse tremendous progress made by Ohio's Medicaid expansion and endanger access to health care for hundreds of thousands of Ohioans.

- It would raise costs of medical care through premiums and increased co-pays on the poorest of families, including those earning less than the federal poverty line. Research shows that increased costs cause low-income enrollees to drop out of health insurance programs and plans.
- The increased costs of 'Healthy Ohio' will lower enrollment by 8.9 percent (state forecasts) to 15.0 percent (Dague, 2014), threatening the health of individuals and the financial stability of health care providers who will tend to their medical crises.
- The incentives underpinning 'Healthy Ohio' are unfair to unbanked families living with limited transportation options, in neighborhoods with limited access to healthy food and places to exercise. Many low-income families will not be able to attain incentive points that offer access to additional health care.
- Because of historically depressed earnings, minority communities rely on Medicaid. The threat of 'Healthy Ohio' is particularly ominous for minority families and communities.

The importance of Medicaid in Ohio

Medicaid provides health insurance for people less than 65 years old who lack health care through their employer and cannot afford private insurance. A quarter of Ohioans are insured through Medicaid. Ohio's successful Medicaid expansion has given 670,000 Ohioans access to health care, with promising results. Preventive care, like cancer screenings and check-ups, enables illnesses to be caught and treated early, which saves costs, dramatically reduces suffering and boosts opportunity for a healthy and productive life. Care reduces the spread of infectious disease, helping everyone in our communities, including people with private coverage. Insurance and regular care can prevent financial crises 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] Medicaid helps prevent these financial disasters.

The 'Healthy Ohio' plan

The 'Healthy Ohio' 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 demonstration projects that promote certain objectives: 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 efficiency and quality of care for these enrollees. The plan does not further these objectives and should not be approved as a demonstration project.

1. 'Healthy Ohio' 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 with the waiver compared to projections without the proposed waiver. These people would have nowhere else to turn for health coverage; they are not likely to have coverage through their employer and their income would be too low for subsidies to purchase marketplace coverage.

2. 'Healthy Ohio' 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 Ohio's Medicaid program under the rules proposed in the plan. The summary of the proposal forecasts a 126,000 to 140,000 (8.9 percent) plunge in enrollment in each of the five years of the demonstration period compared to projections under the current plan.[2] The hardship created by the proposed rules would force people to drop out or not enroll.

The waiver 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. The U.S. Department of Health and Human Services itself published research in July 2015 that described how increased costs make it harder for poor families to get care and maintain coverage. Key findings included:[3]

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[1] Christopher 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

[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

- Low-income patients are especially sensitive to costs. Modest co-payments can reduce use of necessary medical care.
- Medical fees, premiums, and co-payments contribute to the burden on poor adults who need care.
- The problem is worse for those in deep poverty, who have no money for out-of-pocket medical expenses, including co-pays for medical visits.

The Rand Corporation's Health Insurance Experiment, a long-term, experimental study of cost sharing, found that providing health care without cost improved hypertension, dental health, vision, and selected serious symptoms among the sickest and poorest patients.[4] These are the kinds of benefits Ohio is seeing through the successful Medicaid expansion.[5]

Imposing costs has the opposite effect. A recent study by Laura Dague 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 enrollment for adults and children. These effects are concentrated in the first few months: enrollees are 12 to 15 percent more likely to leave the program within 12 months.[6] As mentioned, the state's proposal itself identifies a decline of 8.9 percent in coverage.

The 'Healthy Ohio' lock-out provision will further reduce access to care. If patients miss two monthly payments or paperwork deadlines, they lose coverage. Unpaid premiums must be repaid (even for months when no care was received!) before care can be regained.

A decline in Medicaid enrollment will hurt providers. For example, if someone who has not enrolled in Medicaid because of the 'Healthy Ohio' premium breaks a leg, Medicaid coverage will not start until the first premium is paid. That means 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 the coverage afforded by the Medicaid expansion.

3. 'Healthy Ohio' will not result in improved health outcomes.

The waiver proposal will narrow health care access, hurting outcomes patients who have especially pressing needs for continuous care. Poverty increases likelihood of chronic diseases like diabetes, hypertension and depression.[7] Continuity of care matters in managing these

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[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

[5] 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

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

[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/

diseases.[8] Barriers that interrupt consistent, ongoing care hurt health outcomes. Research cited above, including by the United States Department of Health and Human Services, amply demonstrates how the increased costs of the waiver proposal – including a $75 co-pay for inpatient hospitalization - threaten access to health care.

The health savings account model itself, upon which 'Healthy Ohio' is predicated, is the wrong model for poor patients. It is based on a tax-advantaged insurance scheme for high-income employees of large corporations and yields modest savings as people ration their own care.[9] The monthly statements of Healthy Ohio's "Buckeye Accounts," (based on a complex system of 'points,' not dollars) may cause Medicaid enrollees to ration health care, avoiding essential care as they watch their meager stockpile of points dwindle month after month. This is the wrong model for this population. The health care problem of the poor in America is *underuse* of medical services.[10]

The conservative Rand 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."[11]

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

This waiver plan will make Medicaid less efficient. The proposal itself reveals that per-member, per-month costs increase under 'Healthy Ohio' relative to the current program.

In addition, the proposal contains several so-called "incentives" identified as innovative service delivery features intended to improve health outcomes or administrative efficiency, but the incentive points would be unattainable for many enrollees because they would 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.

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[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] Karen Davis, Michelle M. Doty and Alice Ho, "How high is too high? The implications of high deductible health plans", the Commonwealth Fund, 2005 at http://tinyurl.com/j7qt2u2

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

[11] "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

- 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.[12] Cleveland ranks as one of the most unbanked large cities in the nation.[13]
- Lack of transportation has been identified as a leading problem for the low-income population in Ohio.[14] 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.

Incentives in health care have high costs for start-up, marketing, and administration. Evaluations have identified specific problems that prevented attainment of health goals or reduced care for some beneficiaries.[15] The evaluation metrics of the ‘Healthy Ohio’ proposal are not gauged to identify who will be helped or hurt by the incentives, making it of limited use as a model.

‘Healthy Ohio’ would disproportionately harm minority communities. Medicaid serves low-income patients. Earnings of black and Hispanic workers are, on average, lower than white workers. Earnings for black Ohioans plunged more deeply since the recession, and have not recovered to the level of 1979.[16] Almost two-thirds of Ohio’s Medicaid enrollment is white but minorities are disproportionately represented because of low wages. While 12 percent of Ohio residents are African American and 4 percent are Hispanic, 22 percent of non-elderly Medicaid enrollees are black and 5 percent Hispanic. To the extent the ‘Healthy Ohio’ plan hurts all Medicaid enrollees, it disproportionately hurts minorities.

This is of particular concern because of health disparities in Ohio.[17] The 2016 Health Assessment by the Health Policy Institute of Ohio found black Ohioans were much more likely than other groups to have poor outcomes for many of the metrics reviewed, including shorter life

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

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

[14] 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

[15] 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.

[16] Ohio’s racial wage gap has widened despite white wage decline over the past decade and a half. Black workers earned over 90 percent of what white workers earned per hour in 1979; by last year that ratio was just over 75 percent. White workers earned $16.87 an hour at the median in 2014, down from a peak of $17.81 in 2002. Black worker wages in Ohio have plunged, never recovering to their 1979 level of $15.90 in 2014 dollars. Last year, Ohio’s median black worker earned just $12.81 an hour, a more than $3.00 hourly pay cut since the peak a few decades ago. Data limitations prevent us from providing details about other demographic groups except to say Hispanics as a group earn less than black or white workers. See Amy Hanauer et.al., State of Working Ohio, Policy Matters Ohio September 2015 at http://www.policymattersohio.org/sowo-aug2015

[17] See goals of the Statewide Health Disparities Collaborative at http://www.ohiohealthdisparitiescollaborative.org

expectancy and a higher infant mortality rate—key indicators of the overall well-being of a population.[18]

Thank you for this opportunity to comment on Ohio’s Section § 1115 demonstration application. If you have questions, or would like to discuss this further, please contact Wendy Patton at wpatton@policymattersohio.org.

Sincerely,

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Policy Matters Ohio

[18] Health Policy Institute of Ohio, State Health Assessment and State Health Improvement Plan, Draft 2016 State Health Assessment, http://www.healthpolicyohio.org/sha-ship/