New Medicaid Waiver Proposal Will Disrupt Coverage and Increase Costs

Medicaid provides health care to 1 in 4 Ohioans

Medicaid is a joint federal-state health insurance program for low-income people. About 2.9 million Ohioans, or 25 percent of the state's population, are enrolled in Medicaid. Medicaid enrollees do not pay a monthly premium for insurance, but they do make co-payments for some services, such as pharmacy, dental, and non-emergency use of the emergency room.[1] The state contracts with managed care organizations (MCOs) to handle payments to medical providers. In this arrangement, the state pays a set amount per month for each person enrolled, (a "capitated rate") to the MCO to enroll Medicaid-eligible people and pay for their care.

Prior to 2014, in Ohio, low-income childless adults, and parents above 90 percent of the federal poverty level, were not covered by Medicaid in the state. This is the target population for the expansion of Medicaid under the Affordable Care Act (ACA). Currently, 630,000 people are covered through the extension. Data show that the extension improved care by transitioning services from expensive hospital emergency departments to more routine, and coordinated, outpatient settings.[2]

How the Healthy Ohio Waiver threatens coverage for over 1 million Ohioans

The 2016-2017 state budget bill requires the Ohio Department of Medicaid (ODM) to apply to the federal government for permission to change, or "waive," fundamental Medicaid rules. The waiver would require all non-disabled adults on Medicaid who currently qualify based on income[3] (between 0 and 138 percent of the FPL) to pay premiums into a modified health savings account (HSA). The premium requirement applies to over one million adult Ohioans who are currently enrolled through the extension or as parents under previous categories on the basis of income.

Premium requirements interfere with participation and increase costs

Premiums have been a feature of Medicaid waiver programs in other states. In the early 2000s, Oregon increased premiums for adults in its Medicaid program under 100 percent of FPL through a waiver. After implementation of the premium increase, enrollment dropped by nearly 50 percent (50,000 people), and the biggest drop in enrollment was among enrollees with the lowest income. About one third of people who were surveyed after disenrollment said it was due to premium costs, and focus group results said that in addition to premium costs, strict guidelines for adherence were a barrier to staying enrolled.[4]

A study of Wisconsin's experience with Medicaid premiums shows that the implementation of monthly premiums resulted in a decline in program enrollment. Premiums were applied to

adults starting at 150 percent of FPL and children at 200 of FPL, so even at higher income ranges than Ohio is proposing, program enrollees were more likely to exit the program.[5]

Arkansas recently eliminated the imposition of health savings accounts and cost-sharing requirements on participants below 100 percent of the federal poverty level. The state estimates that this will cut administrative costs in half.[6]

Research suggests that the cost of administering nominal premiums for Medicaid enrollees outweighs the value of the premiums. The state of Virginia implemented a $15 monthly premium for each child enrolled in Medicaid with family income between 150 and 200 percent of the FPL. The state eliminated this premium when it found that 4,000 children were going to be disenrolled due to premium non-payment and that the state was spending $1.39 on administration for every $1 in premiums collected.[7]

How Healthy Ohio would operate

Total premium payments from Healthy Ohio participants would be equal to the lesser of 2 percent of annual family income or $99, annually, and deposited into a modified HSA known as the Buckeye account. These payments would be made in monthly installments. In addition to the requirement to pay premiums, there are multiple components of this program that would limit the ability of low-income individuals to access coverage and care. These include a lock-out period for failure to pay premiums, no requirement to cover all essential health benefits (despite being a requirement of the ACA), and instituting a cap on yearly and lifetime expenses (also disallowed by the ACA).

The Department of Medicaid is required to make a deposit of $1,000 into each Buckeye account, but only after an initial monthly deposit is made by the participant. Medicaid's deposit must be spent first toward medical expenses before Medicaid managed care plans cover any services. The individual's contributions are spent on co-payments for services.

The Department of Medicaid and MCOs must create a complicated and costly swipe card system that separately tracks expenditures from participants' funds and Medicaid funds, and then signals MCOs to pay providers directly when the card balance reaches zero. The state has to pay 50 percent of all administrative costs, a lower rate than the matching requirements for other parts of the program.

Healthy Ohio differs fundamentally from the Indiana plan

Ohio's waiver proposal is modeled on one that was approved in Indiana. The waiver in Indiana served as its method of expanding Medicaid to all adults with incomes less than 138 percent of the federal poverty line FPL; however, in Ohio, Medicaid expansion is already implemented.

The following table lays out key components of the already approved Indiana plan and the proposal laid out in the Ohio budget. Note the differences between the main features of the program.

New Medicaid Waiver Proposal will Disrupt Coverage and Increase Costs

KEY PLAN ELEMENTS	INDIANA- Approved waiver	OHIO- Final Budget (H.B. 64)
Decreases the number of uninsured, and increases the number of individuals with Medicaid coverage	YES	NO
Limited to individuals who are over the age of 21	YES	YES
Individuals with incomes at or below 100% of FPL are charged premiums as a condition of eligibility for Medicaid	NO	YES
Total participant contribution	Monthly premiums are the greater of 2% of income or $1.00	Monthly premiums are equal to the lesser of 2% of annual family income or $99, made in monthly installments
Limits on what charities, employers, or health care providers can contribute to a participant HSA	NO	YES
Annual amount contributed by the Department of Medicaid	Difference between $2,500 and the participant's contribution	$1,000
Assumes higher payments to providers	YES	NO
Time a participant is locked out of Medicaid if premiums and/or documentation are 60+ days late	Adults between 101-138% FPL are locked out for 6 months; participants at or below 100% FPL enrolled in basic health plan w/ co-pays and w/o dental and vision	Until premiums are paid
Includes provisions preventing participants from losing coverage if they were unable to pay premium due to domestic violence, living in a county with a disaster declaration, being medically frail, and other exceptions deemed necessary	YES	No, but does not disenroll pregnant women for failure to pay
Participants provided with basic Medicaid coverage if they fail to provide premiums	YES (at or below 100% FPL)	NO

PLAN ELEMENT	INDIANA- Approved waiver	OHIO- Final Budget (H.B. 64)
Voluntary referral to workforce services	YES	YES
Requires 90 days of retroactive coverage requirement from the date of application.	NO	NO
Allows for expanded presumptive eligibility determination by community mental health centers and health departments	YES	NO
Requires coverage of all essential health benefits designated by the ACA	YES	NO
Yearly and lifetime limit on benefit payouts	NO	YES

Source: Ohio House Bill 64, 131st General Assembly, R.C. Secs. 5166.40 to 5166.408; CMS, Special Terms and Conditions, Healthy Indiana Plan, Waiver 11-W-00296/5, January 2015.

[1] http://medicaid.ohio.gov/FOROHIOANS/AlreadyCovered/MedicaidCopays.aspx
[2] Presentation of John McCarthy, Medicaid Director, to the Senate Finance Committee, May 5, 2015, p. 23.
[3] This includes adults in the Medicaid extension and covered families and children categories of eligibility.
[4] Samantha Artiga and Molly O'Malley. *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences*. Kaiser Commission of Medicaid and the Uninsured. May 2005. http://kff.org/medicaid/issue-brief/increasing-premiums-and-cost-sharing-in-medicaid/
[5] Laura Dague. The effect of Medicaid premiums on enrollment: A regression discontinuity approach. *Journal of Health Economics*. May, 2014.
[6] Marquita Little, *Arkansas Approves Private Option Improving Security for Families, Hospitals & State Budget*, Arkansas Advocates for Children and Youth, February 6, 2015.
[7] Tricia Brooks. *Handle with Care: How Premiums Are Administered in Medicaid, CHIP and the Marketplace Matters*. Georgetown University Health Policy Institute, Center for Children and Families. http://www.healthreformgps.org/wp-content/uploads/Handle-with-Care-How-Premiums-Are-Administered.pdf#sthash.4zQfh6Mv.dpuf

For further information, please contact jhoneck@communitysolutions.com.
1501 Euclid Ave., Ste. 310, Cleveland, OH 44115
101 E. Town St., Ste. 520, Columbus, OH 43215
P: 216-781-2944 // F: 216-781-2988 // www.CommunitySolutions.com
Published: November 2015