Ohio Senate Medicaid Committee
Testimony on Sub. H.B. 64, 131st G.A., Budget for Department of Medicaid

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May 20, 2015

Chairman Burke, Ranking Member Cafaro, and members of the Senate Medicaid Committee, thank you for taking the time to hear my testimony on a key Medicaid provision in Ohio House Bill 64.

My name is John Corlett and I am the President and Executive Director of The Center for Community Solutions. CCS is a nonpartisan think tank focused on research and analysis of health and human service issues with offices in Cleveland and Columbus. Prior to this I was a Vice President with The MetroHealth System and also served as State Medicaid Director for the State of Ohio. I would like to share our perspective on language that was added by the Ohio House to create the Healthy Ohio Medicaid program.

When the Ohio House of Representatives passed Ohio Substitute H.B. 64, they added language directing the Ohio Department of Medicaid to "establish a Medicaid waiver component to be known as the Healthy Ohio program." At the time, proponents argued that it was identical or very similar to the recently approved Medicaid plan in Indiana called the Healthy Indiana Plan (HIP).

The proposed Healthy Ohio program differs in many critical ways from the plan adopted in Indiana. For example, the Ohio plan includes children, and it would terminate a child's Medicaid coverage for a full year if their parent was either late with their premium payment or paperwork. Indiana's plan includes no similar provision. Unlike HIP, the Healthy Ohio proposal provides absolutely no health care coverage for those very poor Ohioans unable to afford the cost of a premium. Unlike Indiana it doesn't offer any special protection for the medially frail or those with serious mental illness. Nor does it place a cap on the percent of household income a participant(s) would have to pay to maintain coverage.

Perhaps most importantly, the Healthy Ohio proposal, unlike Indiana's plan, wouldn't result in more people gaining health care coverage. It would, instead, result in thousands of very poor children and adults losing health care coverage over time. It would reverse the progress we've made on reducing the number of uninsured Ohioans, improving infant mortality, expanding access to mental health services and substance abuse treatment. And it would expose the State to higher information system and provider payment costs.

In terms of higher provider payments, the Legislative Services Commission recently estimated that the cost of the mandated 40% increase in provider payments would be $2.2 billion over the two-year period of the budget. I am not aware of any instance where the State has provided across the board increases of this magnitude.

Constructing and negotiating a waiver of this scope and complexity, affecting approximately 85% of current enrollees, could take as long as two years. It would also likely require extensive reprograming of Ohio's Integrated Eligibility System (eligibility determination), and the Medicaid Information Technology System (claims payment). These last two steps could take another 2-3 years and would be costly. If no federal approval for the waiver was obtained, the State might have to pay these costs alone. As a former Medicaid Director, I am very cognizant of the fact that the process of designing, building, and implementing the current Medicaid payment system spanned three Governors and 5 Medicaid Directors. Clearly these types of system changes aren't made overnight.

It's clear that implementing the Healthy Ohio plan would be administratively burdensome for the state, managed care plans, providers, and--most of all--participants. It's this type of complexity and high cost that led Arkansas to recently eliminate the imposition of health savings accounts and cost-sharing requirements on participants below 100 percent of the federal poverty level. They estimate that this will cut their administrative costs in half.

I urge the Senate to drop this language, and instead focus on ways to encourage health care providers to do a better job of engaging consumers as active participants in their health care. Let's focus on improving overall quality, or on ways we might encourage providers to better integrate behavioral and physical health. If we focus our attention there we can improve quality, have better outcomes, and lower costs.

Thank you again for your time. I'm happy to take your questions.