Ohio House Medicaid Plan Markedly Different than Indiana Plan; Thousands of Ohio Children and Adults Would Lose Access to Health Care Coverage

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By John R. Corlett, President and Executive Director
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The Ohio House of Representatives recently passed a budget containing language directing the Ohio Department of Medicaid (ODM) to “establish a Medicaid waiver component to be known as the Healthy Ohio program.” The Ohio Senate is now considering the proposal. Proponents of the proposal have compared it to Healthy Indiana Plan (HIP) 2.0, an 1115(A) Medicaid demonstration that was approved by the U.S. Centers for Medicare and Medicaid Services (CMS) on February 1, 2015. But the Ohio proposal differs in significant ways from HIP. First, children with incomes below 200 percent of the federal poverty level would no longer be eligible for standard Medicaid but instead would be required to enroll in Healthy Ohio. Second, it would deny Medicaid coverage for a year for any Healthy Ohio participant (including children) who was either late with their payment, or unable to make their payment. While the Indiana waiver resulted in more people gaining health care coverage, the Ohio proposal would likely result in hundreds of thousands of children and adults losing coverage. Healthy Ohio would face significant and lengthy scrutiny by CMS, particularly as evidence is mounting in other Medicaid waiver expansion states that similar programs come with significant administrative complexity and cost for states and the federal government.

Ohio’s Current Medicaid Expansion
The Affordable Care Act permitted the State of Ohio to expand Medicaid coverage to what is often referred to as “Group VIII.” This includes adults who are between the ages of 19 and 64 and have incomes at or below 133 percent of the federal poverty level. The expansion became effective on January 1, 2014. As of April 15, 2015, 477,500 Ohioans are enrolled. Health benefits under the program are largely the same as benefits covered under Ohio’s previously existing Medicaid program for covered families and children. These newly covered beneficiaries are enrolled in one of Ohio’s five private Medicaid managed care plans. The federal government covers 100 percent of the cost of the expansion between 2014 and 2016. Beginning in 2017, Ohio will gradually begin covering a small portion of the expansion costs; up to a total of 10 percent by 2020.

Section 1115 Medicaid Research and Demonstration Waivers
The term “1115 Medicaid waivers” refers to Section 1115 of the Social Security Act which gives the Secretary of the United States Department of Health and Human Services the authority to approve demonstration projects which CMS determines promote the objectives of the Medicaid and CHIP programs. In the past, these waivers have been used to expand eligibility to those not otherwise Medicaid or CHIP eligible, to provide additional benefits, and to test delivery system reforms that improve care and/or lower cost. Ohio’s only recently approved 1115 demonstration was the MetroHealth Care Plus waiver that was approved on February 5, 2014, and which expired at the beginning of 2015. The budget passed by the Ohio House directs the director of
the ODM to “establish a waiver,” but a state Medicaid director can’t establish a waiver on his or her own. An approved Medicaid waiver is the result of long and complex negotiations between a State Medicaid program and CMS. Once CMS has given preliminary approval to a demonstration, it then has to be approved by the Secretary of Health and Human Services and the White House Office of Management and Budget. There is also a prescribed method for seeking public comment on a proposed waiver at both the state and federal level that must be followed in order for the waiver to move forward. In short, the process is inherently political, and it isn’t uncommon for national and state advocacy and provider groups, members of Congress, and others to weigh in on pending waiver applications.

**Healthy Ohio Program**

The Ohio House-passed budget proposes to create the Healthy Oho Program. Participation in the program would be mandatory for anyone in the existing Covered Family and Children Medicaid category⁴ as well as the Group VIII Medicaid category. As of April 15, approximately 2,180,570 adults and children are covered in these categories and would be required to participate in the proposed Healthy Ohio program⁵.

A centerpiece of the legislation are “Buckeye Accounts,” described as a “modified health savings accounts.” These accounts would consist of Medicaid funds, contributions made by the individual, and possibly contributions made by others. An account could not have a balance of greater than $10,000 at any one time. Medicaid would be required to deposit $1,000 per adult and $500 per child on an annual basis, but that deposit would not occur until either the participant deposits the greater of 2 percent of their “monthly countable family income,”⁶ or one dollar. Participant deposits would be required on a monthly basis.

The plan allows for employers, and nonprofit organizations to provide up to 75 percent of a participant’s monthly Buckeye Account payment. The individual participant is required to pay at least 25 percent of the required monthly payment. In the case of children, parents or their caretaker relatives are required to make the 25 percent monthly Buckeye Account payment. There is no overall limit for how much a family with children would have to pay into their Buckeye Account. For example, a mother with income at 100 percent of the federal poverty level ($20,090) and three children would be required to pay 2 percent of her monthly income into each account (there is no provision for a joint family account). At this income level, that would amount to approximately $104 or 6 percent of their monthly income.

The managed care plan that offers the health plan in which the participant is enrolled can contribute to the account, but their funds can only be used to pay for “health-related incentives,” and can’t be used to reduce the participant’s contribution.

The plan envisions participants being eligible to earn points for a variety of activities. These include earning 20 points if a participant arranges for his/her monthly Buckeye Account payment to be made electronically from a checking or savings account. A participant can earn up to 200 points annually if he/she achieves health care goals that have been established by the
Ohio Department of Medicaid. They can obtain another 100 points annually if a primary care physician verifies that they have met health care benchmarks established by physicians. The Medicaid director must deposit one dollar into a participant’s Buckeye Account for each point awarded.

The plan proposes a 12-month lock-out period for adults or children whose monthly Buckeye Account payment is more than 60 days late, or if they fail to provide eligibility redetermination documentation more than 61 days after it is requested. This means that the previously eligible adult or child would not be able to obtain health insurance coverage via Medicaid, Healthy Ohio, or CHIP for at least a year even if they were eventually able to pay the premium. Under the plan, a parent or caretaker relative can also terminate a child’s eligibility. Other reasons why a participant might leave the plan include becoming Medicaid eligible under another category (e.g., Aged, Blind and Disabled), becoming a ward of the state, having income that exceeds Medicaid eligibility, and/or exhausting the lifetime payout limit. 7

Healthy Ohio enrollees who cease to participate in Healthy Ohio shall be given any contributions that remain in their Buckeye Account at the time they cease to participate. If the Healthy Ohio participant is a child, their account balance will go to the parent or caretaker relative. Some participants may leave Healthy Ohio because of a rise in income allowing them to purchase private coverage or because of obtaining health care coverage through a private employer; any funds remaining in their Buckeye Accounts will be transferred to “bridge accounts.” Funds in these “bridge accounts” may only be used to pay for costs related to obtaining health care coverage or out-of-pocket expenses for health care services and prescription drugs not covered by their new plan. Healthy Ohio participants who cease participation in the program for reasons other than obtaining private coverage or who are no longer eligible because of an increase in income have no restrictions on how they can utilize funds remaining in their accounts.

Several provisions of the legislation would result in the state having to design a new care management system separate from its current Medicaid managed care program for the Healthy Ohio plan. The plan would likely have different benefits than the current plan, and would have much greater churn than the current plan because of the imposition of copayments and premiums. Requiring the Healthy Ohio plan to pay Medicare rates for professional services as opposed to Medicaid rates would also increase costs substantially. According to The Henry J. Kaiser Family Foundation’s 2012 Medicaid to Medicare Fee Index, Ohio Medicaid on average paid 61 percent of what Medicare typically paid. All of this would have to be taken into account in the development of rates to be paid to the managed care plans participating in Healthy Ohio. This would also likely necessitate changes in Ohio’s Upper Payment Limit program and the franchise fees that hospitals currently pay to support it. CMS is requiring Indiana’s regular Medicaid program to eventually match the higher provider rates paid by Healthy Indiana. In the meantime, they are required to submit an annual report to CMS documenting whether the higher rates paid by Healthy Indiana is resulting in fewer providers participating in the state’s
standard Medicaid program. If there isn’t equal access, the state is required to develop and implement a corrective action plan to assure equal access.

The proposal also seems to envision that the managed care plans would manage the collection of premiums, copays, and the production of monthly detailed statements. The program also requires the development of a Healthy Ohio debit swipe card that can be used by providers to verify participant enrollment and eligibility for covered services, and to provide participants with point-of-service information so that they will know which portion of their Buckeye account is being debited for the service and how much will remain in their account after the service is provided. The mandated increase in provider payments and additional administrative responsibilities placed on the managed care plans would likely require a substantial increase in the monthly capitated payments to the plans. The experience of other states that have implemented premiums or co-payment requirements is that the cost of establishing and maintaining these systems far exceed what is collected.

Table 1. Healthy Indiana Plans Compared with Healthy Ohio Plan

<table>
<thead>
<tr>
<th>KEY PLAN ELEMENTS</th>
<th>INDIANA</th>
<th>OHIO</th>
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<tbody>
<tr>
<td>Decreases the number of uninsured, and increases the number of individuals with Medicaid coverage</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>Limited to individuals who are over the age of 21</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>Individuals with incomes at or below 100% of the federal poverty level are charged premiums as a condition of eligibility</td>
<td>NO</td>
<td>YES</td>
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<tr>
<td>Total contributions is limited to 2% of household income</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>Limits on what charities, employers, or health care providers can contribute to a participant HSA</td>
<td>NO</td>
<td>YES</td>
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<tr>
<td>Assumes higher payments to providers</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Participants locked out of Medicaid for one year if premiums or documentation are 60+ days late</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Includes a provision preventing a participant 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</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Participants provided with basic Medicaid coverage if they fail to provide premiums</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>Voluntary referral to workforce services</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Allows for a waiver of co-pays for non-emergency use of ER</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>Requires 90 days of retroactive coverage requirement from the date of application.</td>
<td>NO</td>
<td>NO</td>
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<tr>
<td>Allows for expanded Medicaid presumptive eligibility determination by community mental health centers and health departments</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Early Periodic Screening Diagnosis and Treatment (EPSDT) services are a required benefit for those up to the age of 21</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Yearly and lifetime limit on benefit payouts</td>
<td>NO</td>
<td>YES</td>
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Healthy Ohio Proposal Would Face Uncertain Future

Waiver projects or demonstrations are meant to research new ideas or methods that are intended to further the objectives of the Medicaid program. It’s not clear what objective of the Medicaid program that the Healthy Ohio proposal would advance. Major obstacles would include, but are not limited to:

- Requiring children to be enrolled in the program is a non-starter. CMS has never approved a waiver that required children to obtain health savings accounts or which locked children out of coverage for up to one year because their parents failed to pay their premiums or were late in providing required documentation. The negative effects on children’s health and academic performance would be profound.
- Constructing a waiver of this scope, affecting approximately 85% of current enrollees, could take as long as two years. It would also require extensive reprogramming of Ohio’s Integrated Eligibility System (eligibility determination), and the Medicaid Information Technology System (claims payment). These last two steps could take as long as 3 years and would be very costly. If no federal approval for the waiver was obtained, the State might have to pay these costs alone.
- There is considerable research and actual experience showing that, when Medicaid cost-sharing or premiums are imposed on very low-income individuals, many tend to drop the coverage or don’t access services. Those who do access services may end up being treated in more costly hospital emergency room settings.
- Mandating that very poor individuals make monthly payments (in a household with more than one recipient, multiple payments) into their Buckeye Account seemingly ignores the reality that over 328,000 Ohio households have no bank account. It’s not clear how these unbanked individuals would actually make such a payment.
- Indiana already had a limited capped health savings account plan in place, but had not acted to expand coverage under the new authority granted under the ACA. The expanded Healthy Indiana Plan, though less comprehensive than Medicaid, will reduce the number of low-income Indiana residents who are uninsured (although certainly not to the same extent Ohio has experienced through its Medicaid extension). In contrast, the Healthy Ohio Plan would almost certainly result in thousands of adults and children losing coverage when they found themselves unable to pay the required premium.
- Unlike Indiana’s plan, Ohio doesn’t propose to provide any Medicaid coverage—not even limited coverage—to those with incomes under 100 percent of poverty who don’t pay the required premiums on time.
- Ohio’s plan also doesn’t make exceptions for things like natural disasters and/or domestic violence that might prevent an individual from being able to make a premium payment. Nor does it provide exceptions for those who are medically frail. Nor are there

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<td>State Medicaid agency required to establish a catastrophic health care plan for those exceeding the annual or lifetime payout limits of $300,000 and $1 million.</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>
any exceptions for persons suffering from a serious mental illness that might impair their ability to make the required payments.

- Ohio’s plan, unlike Indiana’s, doesn’t place a cap on the percent of household income a participant(s) would have to pay to maintain coverage.
- Healthy Ohio proposes to pay providers much higher rates than those paid by regular Ohio Medicaid. Indiana committed to equalizing the rates they pay providers in the Healthy Indiana plan with those they pay through traditional Medicaid by 2018 even though this could expose them to higher costs.
- Implementing the Healthy Ohio plan would be administratively burdensome for the state, managed care plans, providers, and--most of all--participants. Arkansas recently eliminated 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.9

Conclusion
The Healthy Ohio Plan seems misdirected. If the legislature wants to encourage work, it might want to look at Iowa, which became the first state to receive CMS approval to amend its State Medicaid plan to include a supportive employment program for persons with serious mental Illness.10 To reduce unnecessary emergency department utilization, they could look at the successful Red Carpet Care program developed by The MetroHealth System in Cleveland for Medicaid and commercially covered patients. It utilized registered nurse case management, home visits, linkage with community resources, and expedited primary care access to reduce previously high rates of emergency department visits and hospitalizations. More than 10 years ago, the State of Oregon increased premiums for Medicaid adults below poverty. Just nine months later, almost 50 percent of the people previously covered were no longer enrolled and the overwhelming majority were uninsured.11 If that were to occur in Ohio, it would translate into over a million uninsured Ohio children and adults with the overwhelming majority ending up uninsured. If the legislature wants to reduce costs in the Medicaid program, it would be best to focus on those areas of the program with the highest expenditures rather than creating a new, costly, complex, and punitive program which will harm the health and wellbeing of thousands of Ohio children and adults.

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1 Ohio Substitute House Bill 64.
2 The reference VIII Group is based on the section (VIII) of the Affordable Care Act that added the Medicaid expansion eligibility category.
3 The federal government requires states to cover 5 percent in 2017, 6 percent in 2018, 7 percent in 2019, and 10 percent in 2020 and beyond.
4 The legislation would exempt anyone who is a ward of the state as defined in ORC 2111.01 or a minor who is temporary or permanent custody of a public children’s services agency.
5 Ohio Department of Medicaid, Medicaid Managed Care Program Membership Report, April 15, 2015.
6 The legislation does not define “monthly countable family income.”
7 Under the legislation, the Director of the Ohio Department of Medicaid is required to establish a catastrophic health care plan that would be available to Healthy Ohio participants who exceeded either the annual limit of $300,000 or the life time limit of $1 million.
11 Center for Budget and Policy Priorities and Georgetown University Center for Children and Families, Letter to Secretary Kathleen Sibelius regarding proposals for the Iowa Marketplace Choice Plan and Iowa Wellness Plan, September 26, 2013.

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