Policy Matters Ohio

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Testimony to the House Finance Committee

Infant mortality and HB 64

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Good morning Chairman Smith, Ranking Member Drihaus and members of the committee. Thank you for the opportunity to testify today. I am Wendy Patton, a Senior Project Director at Policy Matters Ohio, a non-partisan, not-for profit research organization with a mission of contributing to a more prosperous, equitable, inclusive and sustainable Ohio.

Ohio ranks 48th among the states in infant mortality and 50th in the African American community.[1] Ohio has made a commitment to address its abysmal ranking in part by assuring that low-income pregnant women have access to high quality health care coverage. This advance has been reversed in House Bill 64. Medicaid coverage for pregnancy, family planning services and the treatment of breast and cervical cancer will cease to be available for people earning between 138 percent of poverty (about $22,000 a year for a woman with one child) and 200 percent of poverty (about $32,000 for a family of two). Ostensibly, women can seek coverage in the health marketplace and get subsidized coverage, but there are cracks through which one can fall and lose coverage during a pregnancy.[2]

1) If it's not open enrollment season – which occurs once a year for several months - the pregnant woman cannot enroll in the exchange. Unlike marriage or the birth of a child, pregnancy is not one of those life changes that qualify for a "special enrollment" period. If an uninsured woman becomes pregnant outside of an open enrollment period, she will not be able to enroll in Marketplace coverage. This will leave low-to-middle income pregnant women with few, if any, options for health coverage if Medicaid eligibility is cut back.

2) The "Family Glitch:" Eligibility for Marketplace subsidies is determined not only by income but by access to "affordable" coverage. The definition of "affordable" – for both an individual employee and a family – does not take into account the cost of a family plan. Thus, a whole family can be locked out of access to health care tax credits and cost-sharing reductions when the cost of the covered family member's employer sponsored plan – just for the worker, not for the wife - is less than 9.56% of household income.

3) Low-income pregnant women may not be able to afford qualified health plan coverage. Beyond the family glitch and not being able to enroll outside of open enrollment, many low-to-middle income women may not be able to afford coverage, even in the marketplace. For example, a

[1] Ohio Minority Health Commission, Interview with Executive Director Angela Dawson, April 15, 2015.
[2] Trisha Brooks, "Cuts to Medicaid Pregnancy Coverage: Penny Wise and Pound Foolish," Georgetown University Health Policy Institute, Center for Families and Children, Feb. 12, 2015. http://ccf.georgetown.edu/all/cuts-medicaid-pregnancy-coverage-penny-wise-pound-foolish/

pregnant woman with income at 150% FPL (About $32,000 for a family of three) is expected to pay 4% of her household income for coverage. While prenatal care should be included at no cost as a preventive service, deductibles and other cost sharing would apply to labor and delivery.

4) If low-income pregnant women remain uninsured, they may not get the prenatal care they need to promote a safe, full-term delivery and healthy child. Research has shown that prenatal care is effective in reducing low-weight and premature births. Moreover, it saves money. The cost of hospitalizing a premature baby in a neonatal intensive care unit is around $5,000 per day; 100 days in can cost upwards of a half million dollars. The health system bears the unreimbursed cost of the uninsured. The mother and baby bear the suffering and long-term effect of the medical crisis.

5) Access to comprehensive care in the critical first year of life may be compromised. A baby born to a mother covered by Medicaid is automatically eligible for Medicaid coverage for one year, regardless of changes in circumstances that may affect the baby's eligibility as a new applicant. Cutting Medicaid for pregnant women will no longer automatically protect coverage for babies born to women in this income range during that first defining year in which babies make it to childhood or – in the case of too many Ohio children, don't make it.

House Bill 64 should restore Medicaid eligibility for pregnant women earning up to 200 percent of poverty, as well as for family planning services, which are also critical to lowering infant mortality, and for treatment of common diseases that kill women: breast and cervical cancer – in the interest of protecting low-income families.

The Healthy Ohio Plan for Medicaid enrollees is not family friendly. It is complex and requires constant vigilance on the part of enrollees. It bears a cost. Almost 40 years of research finds the choices the poor must make about use of meager resources – between food, shelter, bills, babysitter, gas money – are much more difficult than the fiscal choices of those with more disposable income. Paying for premiums too often do not make the cut. Under the proposed Healthy Ohio plan, people who fall behind in payments can be locked out for a year.

Low-income families should not be charged premiums on top of co-pays for basic health care. No health insurance structure should include periods of lockout, especially not for 12 months. For the well being of mothers and babies, families and communities, hospitals, insurers and employers, we need to maintain coverage for critical women's health coverage – pregnancy, family planning and breast and cervical center – and maintain our state's commitment to broaden access to health care for all Ohioans, instead of narrowing it.