FINANCE SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
Chairman Romanchuk
Ranking Member Sykes

March 21, 2017

Loren Anthes, Public Policy Fellow, The Center for Medicaid Policy

Chairman Romanchuk, Ranking Member Sykes, and members of the House Finance Health and Human Services Subcommittee, thank you for hearing my testimony today. My name is Loren Anthes and I am a Public Policy Fellow at The Center for Community Solutions, a nonprofit, nonpartisan think tank that aims to improve health, social and economic conditions through research, policy analysis and communication. I am here today to offer testimony in regards to Ohio's effort to implement reforms to increase cost-sharing on individuals above 100 percent of the Federal Poverty Level through an 1115 Demonstration Waiver.

During the last biennial budget, the General Assembly developed and passed a change to Ohio Revised Code that directed the Medicaid Director and the Ohio Department of Medicaid to pursue an 1115 Demonstration Waiver with the Centers for Medicare and Medicaid Services or CMS. On September 9th of last year, after two public hearings, including a federal comment period where CMS received over 900 comments, Ohio received notice that the waiver, dubbed "Healthy Ohio", was rejected by CMS on the grounds that the request to charge premiums, regardless of income, would undermine access to coverage and the affordability of care. However, with a new federal administration, comes new priorities and new opportunities.

On March 15th, Health and Human Services (HHS) Secretary Price and CMS Director Seema Verma, who had worked on Ohio's first Healthy Ohio application, issued guidance to Governors[1] across the United States stating that the new policy orientation of CMS would involve more collaboration between CMS and the states utilizing waivers. They specifically highlighted expanded options in regards to copayments and "reasonable, enforceable premium or contribution requirements, with appropriate protections for high-risk populations."

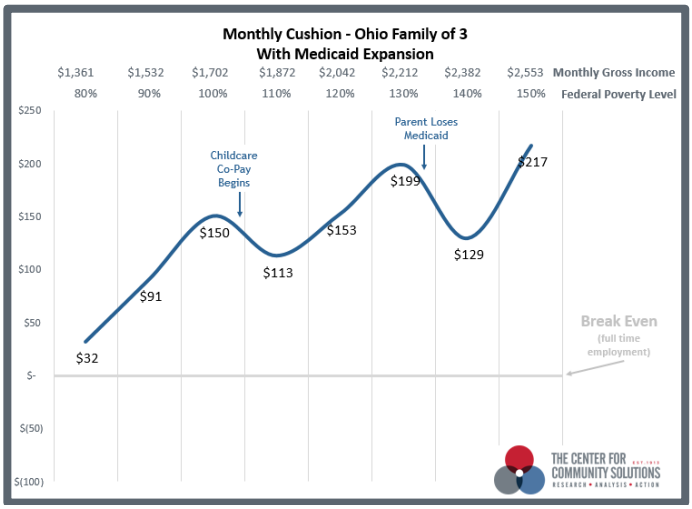
First, in a departure from the 2016's application, the Administration is proposing to limit the cost-sharing to individuals above 100% of the Federal Poverty Level. This is about 21% of the Medicaid expansion population, which itself is about 23% of the total Medicaid population.

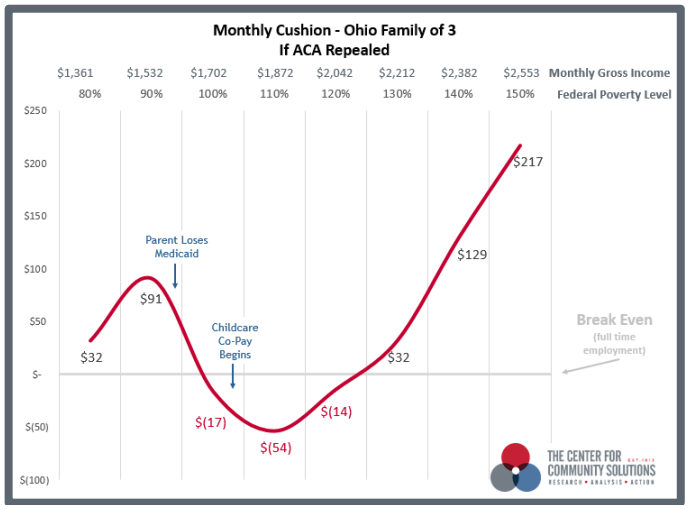
[1] https://www.hhs.gov/sites/default/files/sec-price-cms-admin-verma-ltr.pdf

Here are the estimates[2] by your districts as to who this may affect:

District	Total Medicaid Population	Expansion Estimate	Above 100% FPL
Rep. Romanchuk	18,279	4,265	914
Rep. Sykes	24,293	5,668	1,215
Rep. LaTourette	7,250	1,692	363
Rep. O'Brien	19,508	4,552	975
Rep. Sprague	12,873	3,004	644

States have implemented premiums previously and all experienced similar effects. Evidence from a Kaiser Family Foundation report looked at states who had implemented or increased premiums, including Oregon, Washington, Utah, Vermont, Rhode Island, Wisconsin, and Maryland, and determined that in each case, there was a precipitous drop in coverage that ranged from as low as 30 percent to as high as 77 percent[3]. Part of the reason for this drop, they suggest, is due to the fact that lower income persons devote about 17 percent of their income to health care where that number is about 6 percent for higher income individuals. What's more, individuals who chose to disenroll due to cost were less likely to seek and receive care. This concept is reinforced by research we have recently conducted on "the benefit cliff" which is an analysis that tries to capture how expansion coverage plays in the overall finances of an average household[4]:





As is reinforced by the State's recent "Group VIII" report, Medicaid coverage has provided some economic security to many low-income households who now are better able to address other

[2] www.communitysoltuions.com/Districts
[3] https://kaiserfamilyfoundation.files.wordpress.com/2013/01/increasing-premiums-and-cost-sharing-in-medicaid-and-schip-recent-state-experiences-issue-paper.pdf.
[4] http://www.communitysolutions.com/index.php?option=com_lyftenbloggie&view=entry&year=2017&month=03&day=14&id=60%3Arepeal-of-aca-would-deepen-benefit-cliff&Itemid=264

needs such as housing (48.1 percent) and food (58.6 percent)[5]. Currently, six states have received waivers to charge premiums for adults not otherwise allowed under law.

Second, it is unclear what the administrative burden will be on the State. In Arkansas and Virginia, similar proposals were implemented and later taken down due to high administrative cost. In fact, Virginia found that the state ended up paying $1.39 in administering the HSAs for every $1 collected. Nevertheless, the administration predicts an overall budget savings of about $237.3M over the biennium (4% of the entire Medicaid budget affecting 5% of the population). A financial burden would also be experienced by consumers, however, with nearly 46 percent of Ohioans making less than $15 thousand remaining unbanked or underbanked[6].

Lastly, it may be worthwhile for the legislature to consider the language in Secretary Price and Director Verma's letter regarding "appropriate protections for high-risk populations". In Indiana, who adopted a similar proposal known as the Healthy Indiana Plan or "HIP", also authored by Director Verma for then Governor Mike Pence, the state made exemptions for a list of conditions that qualified individuals as medically frail[7]. These conditions include, but are not limited to, cancer, HIV/AIDS, alcohol and substance abuse, and serious and persistent mental illness. Ohio could consider including its own provisions around medical frailty that are consistent with state policy goals, particularly as they relate to the state health improvement plan, or SHIP, since it is tied to having access to coverage and to provider reimbursement. Such provisions could include women who have just given birth (to combat infant mortality), victims of human trafficking, and those suffering from opiate addiction. And because the waiver itself is not guided by Ohio Revised Code, and is instead governed by the administrative exchange between Ohio Medicaid and CMS, the General Assembly would have to initiate a policy provision via amendment to guarantee medical frailty's inclusion in the application.

Chairman Romanchuk, Ranking Member Sykes, thank you for the opportunity to testify before you today. I would be happy to answer any questions you may have.

[5] http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf
[6] https://www.economicinclusion.gov/surveys/2013household/documents/tabular-results/2013_banking_status_Ohio.pdf
[7] http://www.in.gov/fssa/hip/2465.htm