TESTIMONY
May 11, 2017

Contact: Wendy Patton
wpatton@policymattersohio.org
614.221.4504

Testimony to Senate Finance Subcommittee on Health and Human Services

Medicaid provisions in the House Bill 49 as passed by the House

Good morning Chairman Hackett, Vice Chair Tavares and members of the subcommittee. I am Wendy Patton, of Policy Matters Ohio, a not-for-profit, non-partisan research group with a mission of contributing to a more prosperous, equitable, inclusive and sustainable Ohio. Thank you for the opportunity to testify today on House Bill 49, the budget bill for 2018 and 2019, as passed by the House of Representatives. In today's testimony, we address the inefficiencies and inequity of work requirements, premiums, the Heathy Ohio plan and Controlling Board oversight of Medicaid funds.

Work requirements: Instead of simply covering working-age Ohioans making up to 138 percent of the federal poverty line, the 2018-19 budget bill as passed by the House limits Medicaid expansion coverage to Ohioans who are 55 years and older; employed; have intensive health needs; or are enrolled in school, occupational training or substance abuse treatment. This narrowing of eligibility ignores labor market realities.

Medicaid expansion today covers people who are working (who would remain covered under the eligibility provisions proposed by the House) as well as those who are looking for work (who would lose eligibility). The Ohio assessment of Medicaid expansion found 43 percent of enrollees were employed, and 75 percent of those not employed were looking for work.[1] It is that group – job seekers – who will be hurt by the House's changes in eligibility.

Turnover is high in Ohio's largest employment sectors, which includes sectors like fast food, retail, and customer service.[2] Temporary jobs start and stop, seasonal demand rises and falls, call centers and stores

[1] Ohio Department of Medicaid, "Ohio Group VIII Assessment at http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf

[2] Largest sectors – see Career One Stop of the US Department of Labor at https://www.careeronestop.org/Toolkit/Careers/careers-largest-employment.aspx?location=OH&currentpage=1; on turnover, see US Bureau of Labor at https://www.bls.gov/news.release/pdf/jolts.pdf; in February 2017 the rate of monthly total separations (separations as a share of total employment in that month) was 3.4 percent across all jobs but in retail it was 4.7 percent and in food and accommodations, 6.1 percent.

and restaurants open and close. People working in low-wage jobs experience stops and starts in employment through no fault of their own. HB 49 would lock those whose jobs end out of health care.

Job seekers are not the only group who would be harmed. Others could also easily fall outside of eligibility parameters proposed the House: a husband who cannot work because he is taking care of his ill wife, or someone who suffers from a mental illness that is not included as an "intensive health need."

Healthy Ohio plan: The House budget bill revives last year's failed "Healthy Ohio" waiver proposal, which would have charged Medicaid enrollees premiums and locked them out of the program for non-payment or missing paperwork deadlines. A thousand Ohioans wrote to the federal government and asked that Healthy Ohio be rejected. It was. Because Healthy Ohio put up barriers to coverage, the federal government denied the waiver request in September 2016. Yet Ohio's House of Representatives directs the state to go back and seek approval again for "Healthy Ohio" under a new federal administration.

Premiums: The executive budget included intent to charge premiums to those enrolled in the Medicaid expansion. This too presents a barrier to coverage and would decrease use of health care services. U.S. Department of Health and Human Services research found that increased costs make it harder for poor families to access needed health care and maintain coverage:[3]

- Low-income individuals are especially sensitive to increases in medical costs. Even modest co-payments can reduce access to necessary medical care.
- Medical fees, premiums, and co-payments contribute to the financial burden on poor adults who need to visit medical providers.
- The problem is even more pronounced for families living in the deepest levels of poverty, who effectively have no money available to cover out-of-pocket medical expenses, including co-pays for medical visits.

The Rand Corporation's Health Insurance Experiment, published in 1982, was a long-term, experimental study of cost sharing. The study found that free health care improved hypertension, dental health, vision, and selected serious symptoms among the sickest and poorest patients.[4] A 2014 study published in *The Journal of Health Economics* found that among Medicaid enrollees earning less than 150 percent of the federal poverty level, a premium of up to $10 a month is likely to cause 12 to 15 percent to drop out of coverage within 12 months.[5]

Eligibility requirements that act as barriers to continuous health care coverage offer a false economy to those who seek to reduce public spending on health care. Consider an enrollee who is locked out because he was laid off. During his job search he has a health crisis – say, a stroke or a heart attack. Once in the hospital, he would be deemed to have an 'intensive heath need' and be re-enrolled in Medicaid - during treatment. The cost of treatment would be higher than maintaining him on primary care through Medicaid, and his health would likely be damaged, maybe permanently. His job search would certainly be delayed. His Medicaid coverage would end when he is well enough to resume his

[3] Office of the Assistant Secretary for Planning and Evaluation, "Financial Condition and Health Care Burdens of People in Deep Poverty," United States Department of Health and Human Services, July 16, 2015
[4] Robert H. Brook et.al., "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate," http://www.rand.org/pubs/research_briefs/RB9174.html
[5] Laura Dague, "The effect of Medicaid premiums on enrollment: A regression discontinuity approach," Journal of Health Economics 37 (2014) 1-12.

job search and no longer has 'intensive health needs.' Without primary care to maintain his coverage, this cycle of crisis could keep continuing. This is no way to treat Ohioans, nor is it an efficient way to control health care costs.

Further, there are new administrative costs associated with complex eligibility requirements and oversight of premiums in the Medicaid program. Will the managed care organizations bear the burden, or the counties, and where will the funding for administration come from?

Controlling Board oversight. The House budget bill would withhold Medicaid expansion funding and make it subject to Controlling Board approval, which could be withheld if the state is not making 'satisfactory' progress on obtaining the 'Healthy Ohio,' and other, waiver applications. The Controlling Board would have a right to approve or withhold Medicaid funding once every six months.

It is not clear what 'satisfactory' means, in this context. This capricious proposal threatens treatment plans and business plans. How can hospitals, clinics and health care providers know how to staff themselves, and how can they formulate treatment plans, with Medicaid funding certainty that lasts for just six months and is predicated on arbitrary performance outcomes? The situation would be untenable even if Ohio were not in the middle of a public health crisis, the drug epidemic.

In addition, infrastructure would have to be developed for oversight and eligibility determinations outlined in the House bill. How will state investment in the necessary administrative system be justified with a six-month framework of funding certainty?

Ohio's Medicaid expansion program has been profoundly successful. Under it, Ohio's rate of uninsurance among low-income residents fell to the lowest ever recorded. Fully 75 percent of expansion enrollees came into the program without prior health coverage, and a recent Ohio State University analysis showed that 95 percent would not have been able to get health coverage through other means. Of Ohio's Medicaid expansion enrollees, 70 percent had chronic conditions like diabetes, hypertension and depression that, if left untreated, can result in costly, even deadly, medical crises. After gaining health insurance, expansion enrollees overwhelmingly reported better management of chronic conditions, increased use of preventative care, fewer unmet medical needs and reduced medical debt.

Ohio Medicaid expansion's success in connecting low-income residents with consistent health care stands in sharp contrast to HB 49's embrace of work requirements, premiums and lock-outs, which we can expect will reduce access for those who need it most.