August 4, 2016

The Honorable Sylvia Mathews Burwell
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Burwell,

The undersigned organizations write in response to your request for public comments on Ohio's proposed Section 1115 Medicaid demonstration, the Healthy Ohio Program.

Ohio's Medicaid expansion has been a clear success: the state's uninsured rate among non-elderly adults has dropped from 16.3 percent to 9.3 percent since 2013.[1] A study of the 2013 early expansion of Medicaid in Cuyahoga County found participants had better access to primary care services and were better able to access prescription drugs for chronic conditions such as hypertension than those who remained uninsured.[2] And spending in the state's Medicaid program has come in below projections even as more than 600,000 Ohioans gained coverage due to expansion.[3]

Despite the success of its expansion, Ohio is seeking to make significant changes through a waiver modeled on the Healthy Indiana Plan 2.0 (HIP 2.0). Under Healthy Ohio, *all* non-disabled adults ages 18 to 64 (including parents eligible for Medicaid prior to health reform) would have to make monthly contributions to an account modeled on a health savings account (HSA). People who miss their premium payments would be disenrolled from coverage and would be barred from re-enrolling until they pay the premiums the state says they owe.

Ohio estimates that enrollment under Healthy Ohio will be *9 percent lower* than if its Medicaid program continues as is. This projection is consistent with a robust body of research that shows charging premiums and co-pays to people living in poverty makes it less likely they will enroll in coverage.

Among the criteria CMS has adopted for approving demonstration projects is that they must "increase and strengthen overall coverage of low-income individuals in the state." There is ample evidence that Ohio's proposal would make it harder for low-income Ohioans to

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[1] Robin Cohen, Michael Martinez, and Emily Zammitti, "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2015," Centers for Disease Control and Prevention, May 2016, http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf.

[2] Randall Cebul, *et al.*, "MetroHealth Care Plus: Effects of a Prepared Safety Net on Quality of Care in a Medicaid Expansion Population," *Health Affairs*, July 2015, http://content.healthaffairs.org/content/34/7/1121.full.

[3] Jim Siegel, "Lower Medicaid spending helped Ohio's budget amid revenue shortfall," *The Columbus Dispatch*, July 7, 2016, http://www.dispatch.com/content/stories/local/2016/07/07/lower-medicaid-spending-helps-state-budget-land-on-solid-ground.html.

maintain their health coverage and obtain needed health care. Implementation of Healthy Ohio would reverse the progress the state has made in recent years. CMS should deny Ohio's application.

Our comments on key provisions of the waiver proposal follow:

Premiums for adult Medicaid beneficiaries. The state requests a waiver to charge a prorated monthly premium equal to the lesser of 2 percent of annual income or $99 to all enrollees other than pregnant women. (This works out to about $2 a month for people with incomes at 25 percent of the poverty line, $5 a month for people at 25 percent, and $8.25 a month for everyone with income over 50 percent of the poverty line.) Coverage would not begin until the first day of the month in which an enrollee pays the premium. For those without a premium obligation — which includes pregnant women and people with no income — coverage would begin the first day of the month their application is approved.

No state has been allowed to charge enforceable premiums to people with income below the poverty line. In Indiana, people with incomes below the poverty line who don't pay a premium get a lesser benefit package. And in Iowa and Montana where premiums begin at 50 percent of the poverty line, unpaid premiums for those with incomes below poverty are treated as a debt owed to the state. In these states, people are not disenrolled from coverage when they fail to pay, as Ohio proposes.

Moreover, whether or not Ohio's proposal aligns with other Medicaid expansion waivers is not relevant in evaluating whether it should be approved. Ohio has to show that its proposal fulfills the criteria for a demonstration project, and it does not particularly because of its impact on current beneficiaries. Ohio says its proposal will promote the "appropriate use of healthcare services" and "increase the use of preventive services" (page 8 of the proposal). A robust body of research shows the opposite would likely occur; charging premiums and co-pays to people living in poverty make it less likely they will enroll in coverage and obtain needed care.[4] This is why the state projects enrollment under Healthy Ohio would be 9 percent lower than if its Medicaid program continued in its current form.[5] Healthy Ohio does not meet CMS' criteria for waivers which states they must "increase and strengthen overall coverage of low-income individuals in the state."[6]

Penalties for failure to pay premiums. Under Healthy Ohio, a person who misses premium payments for 60 days will be disenrolled from coverage and cannot re-enroll until they have made back payments. As mentioned, no state has been allowed to disenroll people with incomes below the poverty line from coverage when they miss premium

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[4] Office of the Assistant Secretary for Planning and Evaluation, "Financial Condition and Health Care Burdens of People in Deep Poverty," July 16, 2015, https://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty.

[5] Ohio Department of Medicaid, "Healthy Ohio Section 1115 Demonstration Waiver Summary," April 2016, http://medicaid.ohio.gov/Portals/0/Resources/PublicNotices/HealthyOhio-Summary.pdf.

[6] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html.

payments, and a lockout that requires repayment shouldn't be approved for people at any income level.

Eligibility for Healthy Ohio. Ohio's proposal would not only affect the adults who gained coverage through health reform's Medicaid expansion. It would charge premiums, delay coverage, and terminate coverage for non-payment for low-income parents who were eligible for Medicaid prior to health reform, 18-year old children, pregnant women, and young adults between the ages of 18 and 26 who are aging out of foster care, among other eligibility groups. It is likely that many beneficiaries in these groups, as well as those in the expansion group, have serious health needs, and Healthy Ohio would disrupt the care they are getting now.

"Buckeye Accounts" and incentive system. Under Healthy Ohio, each beneficiary would receive a "Buckeye Account" modeled on an HSA and which will be comprised of funds from three sources:

1) Beneficiaries' monthly premium payments;
2) Points (each of which is equal to $1) for completing certain healthy behaviors;
3) $1,000 from the state.

Ohio says the $1,000 state contribution will be put toward a yearly deductible of the same amount and cannot be used to pay any cost-sharing charges. Monthly premium payments and incentive points would go toward any cost-sharing charges beneficiaries incur when they access covered services as well as unspecified benefits not covered in Healthy Ohio. There are very complicated rules regarding roll-over of the accounts to the next year.

This system is needlessly complex and it's unlikely to improve the health of Ohio's Medicaid beneficiaries. The Buckeye Accounts are modeled on the accounts established as part of HIP 2.0. The evaluation of HIP 2.0's first year shows that a large share of beneficiaries in Indiana are unaware they even have an account and are confused about how the accounts operate, including how getting preventive care can lead to a roll-over of the account in the next year.[7] Given these results and similar findings in Iowa and Michigan where beneficiaries didn't understand the incentives for healthy behaviors, no additional states should be allowed to replicate accounts similar to Indiana's.

Annual and lifetime limits on coverage. Ohio proposes that the maximum benefit a beneficiary can receive be set at $300,000 in a calendar year, and $1 million over their lifetime. Once the costs of coverage for a beneficiary exceeds either of these amounts the beneficiary would be transferred from their Healthy Ohio managed care plan to either fee-for-service Medicaid or a managed care plan outside the demonstration. A person who uses such a large volume of health care would likely have one or more complex health conditions. Yet Ohio provides almost no details on how the transition out of Healthy Ohio would work

[7] The Lewin Group, "Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report," July 6, 2016, http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf.

and what steps the state would take to ensure that vulnerable individuals remain connected to the healthcare providers and treatment regimen they need.

Elimination of retroactive eligibility. Retroactive eligibility is a fundamental protection in Medicaid recognizing that beneficiaries are in a financially vulnerable position unable to afford their health care. Ohio's request to waive this requirement puts newly eligible beneficiaries at risk of being unable to get care and for medical debt if they can get it. It also puts health care providers at risk for bad debt. Further, the state has not proposed a presumptive eligibility system or any other mechanism to mitigate the potential harm to beneficiaries and providers.

State-level opposition to Healthy Ohio. Ohio notes it received 956 comments on its proposal during the state public comment period and only *1 percent* were supportive (page 41). A majority of commenters expressed concern about the proposed premiums, loss of coverage, the danger of forgoing needed care, and the potential disruption of continuity of care for beneficiaries. Despite the overwhelming opposition to Healthy Ohio, the state made no substantive changes, saying it is bound by the state legislation directing it to apply for the waiver. The failure to respond to the comments conflicts with the Section 1115 transparency regulations that instruct states to report on the issues raised by the public and "how the State considered those comments when developing the demonstration application." Ohio instead ignored the feedback it received during the public comment period.

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Ohio's Medicaid waiver proposal would reverse the gains the state has made in recent years in making health coverage more accessible for its low-income residents. Healthy Ohio would not "strengthen overall coverage," "improve health outcomes," or "increase the efficiency and quality of care" in the state, as CMS has said a waiver must do.

The stakes are high: Arizona has submitted a similar waiver to CMS and Kentucky will soon do the same. Ohio projects that fewer people will have Medicaid coverage under its proposal, and it is almost certain that Arizona and Kentucky's proposals would have the same effect. We urge CMS to reject Ohio's proposal and send a clear signal to other states that proposals that would lead to coverage losses and make it more difficult for beneficiaries to obtain needed care are unacceptable.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judy Solomon (solomon@cbpp.org).

American Congress of Obstetricians and Gynecologists
American Heart Association
American Lung Association
American Music Therapy Association
Center on Budget and Policy Priorities
Children's Defense Fund

Community Catalyst
Community Legal Aid Services, Inc.
First Focus
Georgetown University Center for Children and Families
HIV Medicine Association
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