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August 4, 2016

Sylvia Matthews Burwell
Secretary
Health and Human Services
200 Independence Avenue. S. W.
Washington, D.C. 20201

Submitted online at Medicaid.gov

RE: Comments in Opposition to 1115 Demonstration Waiver

I. Introduction

Ohio has implemented several initiatives over the past five years to reduce costs, as well as improve health outcomes and coordinate care for Ohioans. An important part of these improvements was extending Medicaid coverage to more low-income Ohioans by amending the State Plan to cover adults up to 138% of the federal poverty level. As a result of the expansion, Ohio cut its uninsured rate in half and 650,000 previously uninsured people now have health care coverage. These people include an estimated 400,000 with behavioral health needs and 38,000 veterans and family members.[1] Ohio also successfully reduced Medicaid spending -- for the 2016 fiscal year, Ohio's total Medicaid spending was nearly $1.3 billion below estimates.[2] Yet, the proposed Ohio Medicaid waiver plan would create significant barriers to health care for low-income Ohioans. The proposed plan, called Healthy Ohio, imposes premiums, cost sharing, and penalties for nonpayment – all of which have been demonstrated to reduce enrollment, affordability and access to health care.

The Ohio Poverty Law Center, the Ohio Disability Rights Law and Policy Center, The Ohio Domestic Violence Network, ACTION Ohio Coalition for Battered Women, the Ohio Association of Community Action Agencies, and the Ohio Olmstead Task Force submit these comments to describe the harm that would fall upon Ohioans and how the Ohio Department of Medicaid's 1115 Medicaid waiver plan would create deeper poverty and reduce public health as people lose their health care coverage or are not able to get care because of unaffordable premiums or the plan's bureaucratic complexity. Imposing premiums and penalties on the most economically fragile Ohioans is not the way to make our state healthier; it is simply a way for ODM to cut people from the current Medicaid program through what is essentially a cost-shifting program. Under the guise of personal responsibility, Ohio's waiver, if granted, will

[1] http://www.healthtransformation.ohio.gov/Budget/ExtendMedicaidServices.aspx, accessed July 12, 2016

[2] http://www.dispatch.com/content/stories/local/2016/07/07/lower-medicaid-spending-helps-state-budget-land-on-solid-ground.html, accessed July 12, 2016

place untenable financial hardship on Ohio's poorest citizens and cause large numbers of people to go without needed medical care. On behalf of the over 650,000 Ohioans helped by Medicaid as originally intended, we urge CMS to reject Ohio's plan and save Ohio from taking a huge step backward, for the reasons explained below.

II. Ohio Failed to Provide a Meaningful Level of Public Input as Required by 42 CFR 431.412

On July7, the Centers for Medicare and Medicaid Services notified Ohio Department of Medicaid Director McCarthy that the state's 1115 demonstration waiver application met the requirements for a complete application as specified under section 42 CFR 431.412(a). A completed application must include written evidence of compliance with the public notice requirements set forth in 431.408, and include an explanation of how the state considered the comments received during the comment period. The notice requirements were written to ensure a meaningful level of public input at both the state and federal levels, as required by 42 USC 1315(d)(2)(A). Because it failed to address the publics concerns expressed at public hearings and in written comments, Ohio failed to ensure that the public had any meaningful level of input. The Ohio Plan was submitted to CMS without any meaningful modifications, despite the clear and reasoned voices of Ohio's citizens.

As reported to CMS, the Ohio Department of Medicaid received 956 unduplicated comments during its 30-day comment period. An overwhelming 99% of the commenters opposed Ohio's proposal. ODM summarized and categorized the responses. The top concern, raised in 84% of the comments, is that Healthy Ohio would be unaffordable for Medicaid recipients; 63% were concerned that Medicaid recipients would forego medical care in order to meet other expenses. These and other concerns relate directly to two of the four criteria CMS uses to evaluate waiver requests: 1) will the demonstration increase and strengthen overall coverage of low-income individuals; 2) will the demonstration improve health outcomes for Medicaid and other low-income populations. Multiple organizations participating in the public comments cited studies documenting these very real concerns, which give CMS the basis to reject Ohio's application. In spite of the volume, relevance, and seriousness of these concerns, Ohio's cursory response was that ODM is unable to modify the waiver absent a statutory change. Without a more thoughtful response acknowledging, answering or refuting those concerns, Ohio has not complied with the statutory requirement to include public input in designing and submitting its waiver program. The state statute originating this waiver request should not be allowed to trump the federal law mandating public input in Medicaid administrative policy-making.

III. The Healthy Ohio Wavier Will Increase Ohio's Health Disparities by Race and Move Ohio Backwards in Its Need to Improve Health and Wellbeing in Ohio

According to the draft 2016 State Health Assessment released June 24, 2016[3], Ohio ranks in the bottom 25% of states for health outcomes. Even more troubling are the stark racial disparities revealed in the report. To highlight just a few of the multiple examples of disparate health

[3] http://www.healthpolicyohio.org/wp-content/uploads/2016/06/SHA_Full.pdf, accessed July 12, 2016.

outcomes, although black/African-American non-Hispanics comprise only 12.1 percent of Ohio's population, the black infant mortality rate is nearly twice as high as the white rate, and blacks are much more likely than other racial and ethnic groups to experience worse outcomes for the health problems of obesity, low birth weight, diabetes, hypertension and child asthma. Ohio's waiver program will hurt Ohio's African-American citizens at a greater rate than other Ohioans. Over thirty-four percent of Ohio's black population lives in poverty[4]. Any changes in Medicaid that will increase the cost of care, decrease access to care, cause recipients to forego needed care, and create barriers and administrative complications will disproportionately affect Ohio's black and other minority residents, who already face racial, ethnic and economic barriers to care. For a state that struggles to improve all population health outcomes, with so many poor health indicators exacerbated by poverty, implementing Healthy Ohio would be a big step backward in the small progress Ohio has made.

IV. The Healthy Ohio Waiver Does Not Promote the Objectives of the Medicaid Act.

In order for ODM to create and implement Healthy Ohio, it requests waivers of six fundamental precepts of Medicaid. The Center for Medicare and Medicaid Services (CMS) is permitted to grant these requests only if they are for experimental, pilot, or demonstration projects which assist in promoting the objectives of the Medicaid Act. 42 USC 1315(a) requires that the Secretary find that the request:

> (1) will test a unique and previously untested use of copayments,
>
> (2) is limited to a period of not more than two years,
>
> (3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,
>
> (4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and
>
> (5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation. 42 U.S.C.A. § 1396o (West).

In addition, there are general criteria CMS uses to determine whether Medicaid/CHIP program objectives are met. These criteria include whether the demonstration will:

- Increase and strengthen overall coverage of low-income individuals in the state; and
- Improve health outcomes for Medicaid and other low-income populations in the state.

Ohio's application, as described in the Healthy Ohio Program 1115 Demonstration Waiver released April 15, 2016, fails to meet these criteria and should not be granted by CMS.

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[4] https://www.development.ohio.gov/files/research/p7005.pdf, accessed July 12, 2016.

A. Healthy Ohio is Not Unique and has No Demonstrative Value.

1. Co-Payments and Health Reimbursement Accounts Have Already Been Unsuccessfully Tried in Other Medicaid Programs.

CMS has already granted waivers to other states – including, but not limited to, Arizona, Iowa, Indiana, Michigan, Montana, and Pennsylvania – to implement similar premium/cost sharing requirements for Medicaid beneficiaries. There is no demonstrated experimental value in adding another state to that list. The only thing that makes the ODM waiver request unique is that it extends the mandatory premium/cost-sharing requirement to individuals and households living below 50% of the federal poverty level (FPL). Indeed, under the ODM plan, persons with incomes as low as 1% of the FPL (near-zero income) and living in extreme poverty would have to pay a monthly or annual premium. Ohio does not need an experiment to show that individuals living in extreme poverty simply do not have the resources to meaningfully engage in Medicaid cost sharing.

The centerpiece of ODM's proposal, the Buckeye Account, is modeled upon Indiana's POWER Accounts, which are a central feature of HIP Plus. Ohio proposes elements of an HSA-like account that are more complicated and drastic than Indiana's project. Independent analyses of Indiana's available data and reporting raise serious questions about the experiences for the consumers in Indiana. In addition, CMS has commissioned its own study of Indiana's HIP 2.0, which should be completed by the end of 2016. Other states besides Indiana – including Arizona, Arkansas, Iowa, Kentucky, Michigan, and Montana – have implemented or plan to implement similar health savings account programs. CMS should not approve any further HSA-like proposals until the existing demonstration projects have been thoroughly evaluated and identified problems are resolved.

In fact, other states have found that the administrative costs in collecting premiums were more expensive than the amount of premiums actually collected, in some cases in the order of more than $12 million.[5] For example, Virginia ended a premium program when they found it cost the state $1.39 to collect $1.00 in premiums, and Arkansas' Medicaid agency projected that administrative costs would be cut in half after its suspended premium collections for the state's "private option" Medicaid waiver.

2. Healthy Ohio Will Not Increase the "Cost-Conscious" Use of Medicaid.

ODM's stated purpose for the Healthy Ohio Program is to introduce non-disabled Medicaid recipients to a consumer-driven healthcare model where they will be incentivized to use their insurance in a "cost-conscious manner." However, the model makes no mention as to how Ohio Medicaid recipients will be able to comparison shop and actually make conscious decisions on choosing more cost-effective health care. NHeLP, in its analysis of Health Expense Accounts in Medicaid, found that comparison shopping was nearly impossible for Medicaid recipients because of a lack of price transparency.[6] Studies have found that when faced with co-payments and deductibles, individuals tend to reduce as much on essential care as less necessary care,

[5] Center on the Budget and Policy Priorities, "States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility, http://goo.gl.oeKAJr.

[6] NHeLP, Q&A: Health Expense Accounts in Medicaid, David Machledt & Jane Perkins, March 4, 2015.

which can lead to more expensive health interventions like hospital stays and emergency room visits.[7]

In addition to a lack of price transparency, Medicaid recipients face additional hurdles to comparative health care shopping. Many Medicaid beneficiaries lack transportation to allow them to go across town for a cheaper test; they must depend on health care that is close to home, regardless of how the cost compares elsewhere. Many have limited telephone minutes and cannot use them on hold with a variety of doctor offices to comparison shop, do not have internet access to comparison shop online, and do not have child care to utilize while they obtain second opinions on health care decisions. The state's transition to managed care itself still presents a huge learning curve for Medicaid beneficiaries who commonly do not understand the concept. A movement to health reimbursement accounts, a switch confusing to professionals in employer-based plans, would be overwhelming and often unusable for this population.

Current, successful, health care movements are going in the opposite direction of the Healthy Ohio waiver. Instead of requiring individuals to take additional steps to receive needed care, models have moved toward patient-centered medical homes, coordinated care, and addressing social determinants of health to truly treat and improve population health. Over the last decade, ODM has funded programs aimed at payment reform focused on quality over quantity, has implemented MyCare Ohio which aims to coordinate Medicaid and Medicare services in part through a care team, and has instituted continuous coverage for children to avoid churn and gaps in health coverage. The Healthy Ohio waiver is a step backward from those efforts.

B. Healthy Ohio Does Not Provide Benefits to Recipients That Can Reasonably Be Expected to Outweigh the Harm.

The only possible benefit to Medicaid recipients of the Healthy Ohio waiver is that an extremely small percentage of recipients who obtain employment, and who do not use all of the funds in their Buckeye Account, can then roll over those funds to assist with cost sharing in an employer-sponsored plan. The suggestion, however, that a Healthy Ohio Bridge Account will decrease churn back into Medicaid from private health insurance coverage, and increase the proportion of Ohio residents covered by employer-sponsored insurance or market coverage, shows a lack of understanding of Ohio's current labor market and ignores information from the 2016 Ohio Medicaid Assessment Survey.

The Ohio Medicaid Assessment Survey, a study of the movement between public and private insurance, found that, of the new Medicaid enrollees working in 2015, only 5.7% were eligible for an employer-sponsored program. Most Ohio enrollees, who previously had private insurance, lost coverage when they became unemployed.[8] Over 80% of the Medicaid enrolled

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[7] Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MED. PRACTICE MANAGEMENT 317 (1992), http://www.rand.org/pubs/reprints/RP1114.html. For a broader discussion of the relationship between health care utilization and deductibles, *see* Katherine Swartz, Robert W. Johnson Found., *Cost-Sharing: Effects on Spending and Outcomes*, 4 (2010), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1.

[8] http://grc.osu.edu/sites/default/files/inline-files/OMASBriefPublicPrivateSub031416FINAL_0.pdf.

adults are either working or disabled.[9] In 2015, eleven of Ohio's top twelve occupations did not pay enough to raise a family of three above 200% of the federal poverty level and eight of the twelve left a working family of three below 133% FPL.[10] Unless and until Ohio's labor market and wage scales improve, many responsible working individuals and families will depend on Medicaid to support their ability to work. Erecting barriers to Medicaid harms not only the individuals and families locked out of health care, but also Ohio's economy.

1. <u>The Lock-Out Provisions Will Stop Individuals From Re-Enrolling in Medicaid Leaving Individuals Without Access To Coverage.</u>

The "churn" that would significantly increase under Healthy Ohio is the movement of individuals and families in and out of Medicaid, as family finances are strained and recipients are unable to afford premiums and maintain coverage. People who miss two premium payments will be locked out of the program until they pay what they owe and re-enroll. This lack of continuous coverage will lead to discontinuity of care. The Health Policy Institute of Ohio reported that sustained eligibility – like that fostered under Ohio's current Medicaid expansion and Covered Families and Children program – leads to better utilization of health care and better health outcomes for Medicaid enrollees. When enrollees were able to maintain their eligibility ('fully enrolled'), their outcomes were better, their costs were lower, and ED utilization went down. [11] According to a 2013 study in the Journal of Health Economics, any premium – from virtually zero to $10 – will cause churning of between 12–15 percent of the population at any given time.[12] Given that more than one million Ohioans would be subject to the "Healthy Ohio" plan, it may be assumed that up to 150,000 enrollees will drop in and out of enrollment. The lock-out will make it harder to re-enroll and the increased churning will be detrimental, and sometimes dangerous, to the health of recipients.

2. <u>Other states' experiences with premiums already show that premiums are directly related to a decrease in access to health care.</u>

Other states have experienced significant drops in Medicaid enrollment after they implemented premiums. In Indiana, 30% of participants did not make their premium payments.[13] In Maryland, premiums were applied at relatively high income levels, yet 25% of families unenrolled from Medicaid.[14] In Oregon a program with premiums experienced a nearly 50% drop in enrollment,

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[9] http://grc.osu.edu/sites/default/files/inline-files/SDOHPresentationFINAL_1.pdf

[10] http://www.policymattersohio.org/sowo-aug2015.

[11] Health Policy Institute of Ohio, "Medicaid Basics 2015 at http://www.healthpolicyohio.org/wp-content/uploads/2016/03/MedicaidBasics_2015_Final.pdf.

[12] Laura Dague, "The effect of Medicaid premiums on enrollment: A regression discontinuity approach," Journal of Health Economics 37 (2014) 1-12.

[13] "Do Indiana's poor Medicaid recipients really have skin in the game?",IndyStar, February 1, 2016, http://www.indystar.com/story/news/2016/02/01/indiana-tests-charging-medicaid-patients-monthly-contribution/79520120/.

[14] Maryland's Children's Insurance Program: Assessment of the Impact of Premiums. Department of Health and Mental Hygiene, 2004, https//mmcp/dhmh.maryland.gov/docs/MCHPsurvey-FINAL042604.pdf.

with the largest declines experienced by those with no income (58%).[15]

Notably, Ohio's plan will hurt the health outcomes and financial security of the medically frail, persons with serious and persistent mental illness, victims of domestic violence, foster children, women with breast and/or cervical cancer, and individuals living with HIV/AIDS. This enrollment could put other individuals at risk of long-lasting harm, e.g., leading to lower birth weights for babies of new mothers and higher HIV transmission rates among individuals not accessing essential HIV/AIDS case management services. As Ohioans are cut from the Medicaid program for not being able to make monthly payments and bureaucratic mistakes due to an overly-complex system, they will still get sick and need healthcare. But they will be forced to use hospital emergency departments without insurance or the ability to pay.

3. <u>The Healthy Ohio Waiver Does Not Adequately Propose Any Real Benefit to Medicaid Recipients.</u>

The proposed Healthy Incentive Point System allows members to earn "points" by completing healthy behaviors. In addition to the complexity of the proposed incentive point system, the ODM proposal provides little or no information as to what healthy behaviors would be covered by the incentive points system and there are no proposed wellness targets or standards. The proposed demonstration waiver merely provides that "standards for the awarding of points by the State and by providers will be further detailed prior to waiver implementation." There is no timeline for developing those standards and they are not part of the State's waiver request proposal.

Nor has ODF identified how many Ohioans would benefit from the proposed incentive scheme, what healthy behaviors would be promoted, or how the program would be explained to participants. Indeed, the sheer complexity of the proposed "points" system and the low likelihood that Medicaid beneficiaries will understand the program would seriously impede any meaningful participation in this demonstration project.

Moreover, based on the very limited information in the proposed Ohio waiver and the underlying statutory language in the Ohio budget bill, certain activities that could generate incentive points clearly discriminate against low-income families. Lack of transportation, living in neighborhoods with few "healthy food" outlets, volatile and erratic work schedules, and lack of bank accounts would greatly impede the ability of many low-income Ohioans to implement the incentive measures. Low literacy, language barriers, high rates of mental illness, and addiction disorders pose additional barriers to navigating this highly complex and confusing incentive points scheme. The Ohio waiver plan proposes no steps to address those barriers.

The complexity of changing dollars to "points," keeping the core and non-core portions of the Buckeye Account separate for certain services well combined for others, and tracking incentive

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[15] John McConnell and Neal Wallace, Impact of Premium Changes on the Oregon Health Plan, Office for Oregon Health Policy & Research, February 2004, http://www.statecoverage.org/files/Impact%20of%20%Premium%Changes%20in%20the%20Oregon%20Health%20Plan.pdf..

points alongside monthly payments will cause serious problems for both system administrators and Medicaid participants.

Finally, research on the effectiveness of incentives to encourage changes in consumer behaviors has produced mixed results.[16] Ohio's convoluted proposal of earning and using incentive points will add nothing unique to the existing rubric of ideas already under scrutiny. The ten-state Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD) program, currently underway, will provide a broader base from which to design and evaluate incentive programs. It does not make sense to approve an additional healthy incentive program that is lacking necessary information and before the final results of the MIPCD program have been evaluated.

4. Eliminating the Three-Month Retroactive Coverage Period Will Lead to Large Amounts of Medical Debt and Uncompensated Care.

Currently in Ohio, Medicaid applicants with medical bills incurred in any of the three months prior to a successful application, may request retroactive coverage for those months. This "look-back" period allows those who have incurred medical bills while uninsured to get Medicaid coverage if they meet eligibility requirements for the months in question. The Healthy Ohio waiver eliminates this retroactive coverage by disallowing Medicaid coverage – despite meeting all eligibility requirements -- until the first premium payment is made.

Healthy Ohio would mean that a very ill person, who is unable to actively engage in a Medicaid application, will be left with the bills for all of her hospital stay or other treatment prior to the payment of her first premium to the Ohio Medicaid system. The person will incur personal medical debt, despite having been eligible for Medicaid to pay the needed expenses. Because any person eligible for Medicaid, by definition, is unable to pay for medical expenses, hospitals and other health care providers will undoubtedly see a rise in uncompensated care.

In evaluating other states' waiver proposals, CMS has agreed that eliminating retroactive eligibility from the Medicaid program is an untenable policy decision. In an April 5, 2016 letter to Arkansas Governor Asa Hutchinson, who made a similar proposal to CMS, HHS Secretary Sylvia Burwell wrote, "Retroactive coverage is an important Medicaid provision that protects people who need medical care, and who may not know they are eligible for coverage. "Retroactive coverage is especially important when issues with a state's eligibility and enrolment systems lead to unnecessary gaps in coverage." For example, Ohio's sometimes lengthy eligibility determination and appeals process would further expand a Medicaid applicant's gap in coverage if retroactive coverage is eliminated.

[16] http://kff.org/medicaid/issue-brief/an-overview-of-medicaid-incentives-for-the-prevention-of-chronic-diseases-mipcd-grants/

C. Healthy Ohio is Projected to Substantially Decrease the Overall Number of People on Medicaid.

ODM is asking CMS to allow it to change eligibility not only in the Medicaid expansion category, but also for all other non-disabled adults. This includes many of Ohio's most vulnerable populations: parents with incomes below 90% FPL, low-income 18-, 19- and 20-year-olds, children aging out of foster care, and women with breast and cervical cancer. All of these groups will be subject to premiums, a lock out from coverage if those premiums are missed, and no retroactive coverage to reduce medical debt.

According to ODM, Healthy Ohio will lead to a reduction of 126,000 individuals in the first year following its implementation.[17] Independent researchers estimate an even greater decline in that first year.[18] For each successive year of the proposed waiver, ODM projects ever larger decreases in enrollment. Because ODM's projections are based only on the assumption of an 85% penetration rate (i.e., 15% of the eligible population will simply chose not to enroll), the estimated declines fail to account for the inevitable drops in enrollment caused by lock out for failure to pay premiums. This is simply unacceptable. A project that predicts, and indeed relies upon for budget neutrality, the loss of hundreds of thousands of participants over a four-year span, will do significant harm to Ohio. None of the supposed benefits listed by ODM can outweigh this devastating harm.

D. The Cost-Sharing Provisions Will Decrease Access to Care and Will Cause Individuals to Forego Needed Care.

Ohio's plan will charge recipients a monthly fee of 2% of their monthly income, or $99 a year, whichever is less. This calculation means that Ohio's poorest families and individuals will pay a higher percentage of their monthly income than those at the higher end of the scale. For example, a single person living at 10%FPL, or with gross income of $99 a month, will pay a monthly premium of $1.98 or exactly 2% of her income. While another single person, living at 138% of poverty, with income of $1367 per month, will pay $8.25 per month – or about 0.6% of her monthly income.

1. Premiums Imposed on Beneficiaries with All Levels of Income Would Be Devastating.

Imposing these premiums on Ohio's lowest income, and most vulnerable citizens makes their ability to maintain the most basic standard of living even more tenuous. A person living at 50% of the poverty rate, or $495 in gross monthly income, will pay $8.25 a month for Medicaid coverage. If he is lucky enough to live in subsidized housing, he will pay about $150 for rent

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[17] Ohio Department of Medicaid, Healthy Ohio Section 1115 Demonstration Waiver Detail." Public Notice and Request for Common, April 5, 2016, http://medicaid.ohio.gov/PORTALS/0/Resources/PublicNotices/HealthyOhio-Detail.pdf.

[18] Comments by Center for Community Solutions on Healthy Ohio 1115 Demonstration Waiver, filed with the Ohio Department of Medicaid on April 21, 2016, http://www.communitysolutions.com/assets/docs/Health_Policy/2016/healthy%20ohio%20comments%20for%20the%20ohio%20department%20of%20medicaid%20_04212016.pdf.

and utilities. Otherwise, market-rate rent could take up the remainder of his income. If this person has children, there will be child care expenses or school-related costs, as well as higher food and transportation costs. Even if this person/family gets Food Assistance to help supplement their food costs, this will not pay for all of their food, or cover necessary items like clothing, toilet paper or, diapers. Ohio will now be asking a new group of people to decide between buying food for themselves and their families – and health care to prevent, treat, and cure their physical and mental illnesses. It makes no sense to ask people living in poverty to forgo eating so that they can go to the doctor or buy needed medications.

The U.S. Department of Health and Human Services just last year released a report highlighting the impact of medical cost-sharing on low-income populations.[19] The report concluded that (a) low-income individuals are especially sensitive to even nominal increases in medical out-of-pocket costs, (b) modest co-payments can have the effect of reducing access to necessary medical care, and (c) medical fees, premiums, and co-payments could contribute to the financial burden on poor adults who need to visit medical providers. That is especially true for those individuals with incomes of less than 50% of the federal poverty level, who have no money available to cover out-of-pocket medical expenses and whose expenditures on him basic necessities already exceed their income.

By contrast, healthcare as intended by the Medicaid program will create better health outcomes. A Rand Corporation Health Insurance Experiment[20] study found that the provision of healthcare without cost improved hypertension, dental health, vision, and selected serious symptoms among the sickest and poorest patients.[21] Here in Ohio, Metrohealth Hospital's early experiment with Medicaid expansion found that the expansion of readily accessible care, without cost, enhanced health.[22]

2. Administrative Hurdles Will Add Cost and Present Further Barriers to Coverage.

In addition, Ohio provides no explanation in its waiver about how people will actually pay their premiums, and how the physical act of paying these premiums will impose extra burdens on low-income households. Those lucky enough to have a bank account and steady employment can set up an Electronic Funds Transfer (EFT), easily pay their premiums electronically, and earn extra incentives from the State. However, many low-income people do not use or have access to traditional bank accounts. Do they have to travel to their county Job and Family Services (JFS) office to make a payment in person? Or to the offices of their Managed Care Plan? The waiver offers no answers to these questions.

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[19] U.S. Department of Health and Human Services, "Financial Condition of Health Care Burdens of People in Deep Poverty," https://aspe.hhs/gov/basic-report/financial-condition-and health-care-s-burdens-people-deep-poverty.

[20] 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.

[21] Id.

[22] Randall D. Cebul, Thomas E. Love, Douglas Einstadtler, Alice E. Petrulis, and John R. Corlett, "MetroHealth Care Plus: Effects of a Prepared Safety Net on Quality of Care in a Medicaid Expansion Population," Health Affairs, July 2015, Vol. 34 No. 7, 1121-1130, at http://content.healthaffaris.org/content/34/7/11121.abstract.

As with other parts of the waiver, this provision will affect people already overwhelmed by the challenges of poverty and other socioeconomic barriers. For example, other low-income individuals may have difficulty making monthly premium payments if they have language or comprehension challenges (e.g., are non-English speaking, have limited literacy, are intellectually challenged, etc.) Others are forced to be highly transient and in and out of homelessness or their lives are severely disrupted by domestic violence and their bank accounts are no longer accessible.

3. <u>The Healthy Ohio Waiver Will Have an Adverse Effect on Access to Health Care for Children and Pregnant Women.</u>

While the waiver proposal would not technically apply to the children in the household, studies have shown that kids are less likely to visit the doctor if their parent does not have coverage. When Mom drops off coverage after being unable to pay the premium for two months, it's easy to see how the children are likely to also stop getting medical care. This will increase the use of emergency rooms and decrease preventive care – two results that will threaten the health of Ohio children.

If the Healthy Ohio Program is implemented, pregnant women will get coverage the same month their Medicaid application is approved. Under existing regulations, Medicaid is approved as of the first day of the month of application, regardless of when the county JFS approves the application. Over the last two years, since Medicaid expansion, legal aid clients have experienced delays of 90+ days for Medicaid application processing, depending on the county. Others have reported wait times of six to nine months. Healthy Ohio would mean that pregnant women must either pay out-of-pocket for care while they wait for their Medicaid application to be approved, or they will forego care because they can't pay for it. Based on national studies, poor pregnant women will not be able to pay for prenatal care while they wait for their Medicaid application to be processed. They will forego care. Ohio's administrative and legislative officials have committed to reduce Ohio's terrible infant mortality rate. The proposed Healthy Ohio Program does not support that alleged commitment. Instead, the waiver would seriously jeopardize the health of pregnant women and place Ohio's youngest and most vulnerable citizens at even higher risk.

V. <u>Conclusion</u>

The Secretary may only approve 1115 demonstration waiver projects which are likely to assist in promoting the objectives of Title XIX 42 U.S.C. 1315(a). Section 1315(a) was not enacted to enable states to save money or to evade federal requirements, but to "test out new ideas and ways of dealing with the problems of public welfare recipients." S.Rep. No. 1589, 87th Cong., 2d Sess. 20, *reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. The Secretary must consider the impact of the proposed demonstration project on those the Medicaid Act was enacted to protect. *Newton-Nations v. Betlach*, 660 F.3d 370, 380 (9th Cir. 2011). Ohio's proposal will negatively affect the very people the Medicaid Act was enacted to protect. The proposal itself forecasts a significant decrease in enrollment, and locks all members out of health care coverage when they are unable to pay premiums. Ohio's proposal fails to meet the requirements for an 1115 waiver. Worse, it defeats the primary objectives of the Medicaid program by creating difficult and

unnecessary barriers to enrollment and continued access to care. For many Ohioans, these barriers are insurmountable. We ask CMS to reject the waiver request.

Thank you for the opportunity to comment on Ohio's 1115 Medicaid Waiver proposal. If you have questions or would like further information on the issues raised by these comments, please contact Mike Smalz, msmalz@ohiopovertylaw.org, or Linda Cook, lcook@ohiopovertylaw.org.

Sincerely,

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