

Ohio Family Coverage Coalition

Legislative Priorities, SFY 2008-2009

The Ohio Family Coverage Coalition is a coalition of organizations representing diverse interest groups working with the public and private sectors to expand health care coverage for low income families and people by advocating affordable and adequate options. OFCC's Legislative Priorities for the SFY 2008-2009 biennial budget are:

- ✓ **Restore Medicaid Parents' Coverage to 100% Federal Poverty Level:**
In the last budget the General Assembly reduced Medicaid eligibility for parents from 100% FPL to 90% FPL. At least 25,000 parents are expected to lose eligibility because of the cutback. The state fiscal condition is now much improved, and eligibility should be restored to 100% FPL.

- ✓ **Establish the Ohio Healthy Workers Insurance and Premium Assistance Program as a Creative Private-Public Solution:** *Many of Ohio's uninsured adults are employees of small businesses and self-employed persons. Ohio should establish a new private insurance product modeled on Medicaid to provide an affordable health coverage alternative to small employers and self-employed persons without health coverage, and a Premium Assistance program to help low-income employees pay their premium share. Approximately 425,000 working Ohioans fall into these categories.*

- ✓ **Restore Funding to the Full Disability Medical Assistance Program:**
DMA is a state-funded program providing physicians and life-saving prescription drug coverage to indigent, medication-dependent adults who have not met the strict eligibility requirements for Medicaid as disabled. Funding reductions by the legislature since 2003 have kept the program closed to new applicants, with current enrollment below 6,000.

- ✓ **Roll back out-of-pocket costs for low-income people in public health care programs:** *After paying basic living expenses, low-income Medicaid beneficiaries lack extra money to pay even small premiums or co-pays for the health care they need. Numerous studies have shown that cost-sharing causes Medicaid beneficiaries to go without needed health care, leading to more costly treatment down the line.*

Members of OFCC: ABLE (Cleveland), CareSource, The Center for Community Solutions, The Center for Families and Children, Children's Defense Fund of Ohio, Family Service Council of Ohio, The Free Medical Clinic of Greater Cleveland, Legal Aid Society of Cincinnati, League of Women Voters of Ohio, Mental Health Advocacy Coalition, Ohio Association of Community Health Centers, Ohio Association of County Behavioral Health Authorities, Ohio Association of Free Clinics, Ohio Covering Kids and Families Coalition, Ohio Empowerment Coalition, Ohio Hospital Association, Ohio National Organization for Women, Ohio State Legal Services Association, Ohio United Way, Organize Ohio, Public Children's Services Association of Ohio, UHCAN Ohio, Voices for Children of Greater Cleveland, United Way of Greater Cincinnati (revised 8/17/06).

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Ohio Family Coverage Coalition

Legislative Request: Restore Medicaid Parents' Coverage to 100% Federal Poverty Level

In 2005 the Ohio General Assembly cut back Medicaid eligibility for parents, from 100% to 90% of the federal poverty level (FPL). Eligibility dropped for a family of three from \$16,100 annual income to \$14,500. Over 25,000 parents, mostly working, were expected to lose coverage, in order to save an estimated \$37 million state dollars over the 2006-2007 biennium.

Following are important considerations in evaluating OFCC's proposal to restore this coverage.

- The General Assembly enacted the parent coverage expansion in 1999, in order to stabilize low-income families in the workforce. From its inception the number of parents qualifying under the expansion reached 75,000. Almost 90% of them worked. The Ohio Commission to Reform Medicaid, established to recommend structural reforms and cost containment proposals to the General Assembly for consideration in the 2005 budget session, recommended that parent eligibility and services **not** be reduced.
- Poverty level eligibility is modest: 100% FPL = \$16,600 for a family of three, or \$1,383 a month. Most eligible parents work at jobs that pay \$6-9 per hour. Parents who qualify make little money and need to use their discretionary income on other basic necessities.
- Parent Medicaid coverage helps fulfill the promise of welfare reform, allowing working parents to achieve greater economic stability. Unfortunately many begin in low wage jobs without benefits. Lowering the eligibility level only creates an additional barrier to success.
- Parent coverage helps maintain Ohio's dramatically reduced cash assistance caseload, down from 263,000 cases in 1992 to 88,000 cases today. Having health care reduces the likelihood of one's returning to cash assistance after a layoff. For example, Ohio's caseload remained flat during the early 2000's recession, while it increased significantly during the early 1990's. A family on cash assistance costs the state roughly twice what Medicaid alone costs.
- Parent coverage helps insure that working parents will be healthier, thereby enhancing their capacity to function effectively as parents. Research shows that parents whose mental health needs are met through coverage are better able to meet their children's behavioral health needs, while children of parents whose needs go unmet can suffer profound and lifelong behavioral health problems that

are costly to the family and Ohio taxpayers. Investing in parent coverage can help avoid such future costs.

- Research shows that providing parent coverage helps insure that eligible children are enrolled in Healthy Start and receive health care on a timely basis.
- Parent coverage benefits employers unable to provide coverage themselves by increasing employees' morale and productivity while reducing absenteeism and turnover.
- Parent coverage benefits health care providers by reducing the uncompensated care they provide, which in turn reduces their cost-shifting to other payers that drives up everybody's cost.
- Parent coverage, like all Medicaid spending, benefits local economies through the economic multiplier effect. Each state dollar spent on Medicaid in Ohio generates \$3.15 in economic impact and benefit (including the impact of federal matching funds).

More Information: Col Owens (cowens@lascinti.org) or Cathy Levine (clevine@uhcanohio.org)

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Legislative Request: Establish the Ohio Healthy Workers Insurance and Premium Assistance Program as a Creative Private-Public Solution

Background

Of Ohio's 11.2 million people, 1.2 million or 10.7% are uninsured. Almost 1.1 million are adults, most in working families. At present, 63% of Ohioans obtain health care from employer-sponsored insurance (ESI), down from 72% in 1998. Another 2 million Ohioans receive their health care from Medicaid, including 1.1 million children, 500,000 parents, and 400,000 aged, blind and disabled persons. Medicaid grew by 600,000 persons from 2000 to 2005 due to recession, loss of manufacturing jobs with health benefits, and increased health care costs.

While the erosion of ESI has been steady over recent years, especially among small employers, most working Ohioans and their dependents still receive health care through ESI. The uninsured are concentrated heavily among small businesses and self-employed persons, and below 200% Federal Poverty Level (FPL). Medicaid covers the lowest income working poor, those below 90% FPL. Efforts to expand Medicaid to cover more of the working poor have met with controversy. Legislators and the public are not agreed on a public program solution to this problem.

The most creative solution possible in the current environment blends private and public resources. Instead of relying solely on private insurance, which is pricing itself out of the market for small businesses and low-wage workers; or solely on Medicaid, which imposes new costs on taxpayers traditionally borne by employers and employees; the state should combine private and public resources in ways that benefit employers, employees and the public. The following model takes this approach and could serve potentially 425,000 uninsured Ohioans.

Ohio Healthy Workers - A New Insurance Product

A new insurance product would be created to allow small employers and self-employed persons who are without coverage to secure insurance for their employees and themselves. This new product, Ohio Healthy Workers (OHW), would be modeled on Medicaid, both its reimbursement rates and benefit package. While Medicaid cares for many of the state's sickest people in the Aged, Blind and Disabled program, it has a competitive per member per month (PMPM) cost for parents. To the extent OHW resembles Medicaid, it would provide small employers and self-employed persons who have left the private insurance market an affordable alternative.

The state's 2005 Medicaid PMPM cost for parents was \$275. This is expected to rise at a rate of 6% per annum. By contrast, the 2005 average cost of single coverage was \$335 per month. A 2003 small business study reported a monthly average cost of \$402. The percentage increase in premium costs in 2005 was 9.2%; in 2004 it was 11.2%. The

monthly rate differential of \$60-127 represents savings of 18-46%, which will only grow larger over time.

In addition to competitive premium costs, a Medicaid-based product could offer a comprehensive benefit package without the high deductibles and co-pays typical of ESI. Single and non-custodial parent employees not ordinarily eligible for Medicaid could participate in OHW, since there is no public money involved in the purchase. OHW would be marketed by Health Maintenance Organizations (HMO's) and interested insurance companies.

Medicaid-Based Premium Assistance (PA) Program

States currently have the option of Medicaid paying part or the entire premium share of Medicaid-eligible employees whose employers provide ESI but with an employee premium share they cannot afford. This is called Premium Assistance (PA). PA must be "cost effective" to Medicaid, meaning the cost to Medicaid of paying the premium share along with other costs Medicaid normally pays that ESI does not ("wraparound coverage"), cannot exceed the cost to cover the person directly under Medicaid.

Certain waivers allow states to implement expansion programs, including PA programs, with less restrictive criteria than Medicaid normally requires. States can also implement PA with SCHIP funds if available, but Ohio's SCHIP funds are expected to be exhausted by 2008. The waiver approach offers Ohio the best option for establishing PA.

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Legislative Request: Restore Funding to the Full Disability Medical Assistance Program

What is Disability Medical Assistance (DMA)?

DMA is a state health care program that provides prescription medications and primary care physician services for people with very low incomes who are determined to be “medication dependent”. These people are not covered by Medicaid because they do not fit into any of the Medicaid eligibility categories¹. Ultimately, they may be determined to be eligible for Medicaid because of a disability, but the process for determining eligibility is often complicated and lengthy.

DMA provides access to healthcare while the person is recuperating or a Medicaid application is pending. Without DMA, recently disabled people often unable to obtain the primary care and prescriptions they need. They may delay seeking care until they are so sick that they must go to the hospital emergency department, the most costly healthcare option.

How do people obtain DMA?

To qualify for DMA, an individual must have an income that is below \$115/month. Other than a brief period in mid-2005, DMA enrollment has been closed since the summer of 2004 because of budget cuts. Enrollment in DMA has fallen from nearly 30,000 Ohioans in June 2004 to about 5,000 in September 2006. Because DMA enrollment is closed, there is no public safety net for people with very low incomes who need medication and primary care access to manage a debilitating illness.

History of DMA

Disability Assistance (DA) was created in 1995 when General Assistance (GA) was eliminated. Initially, the DA benefit included medical assistance. Later, two separate programs were created: Disability Financial Assistance and Disability Medical Assistance (DMA). Eligibility for DMA was limited to people with very low incomes that are determined to be “medication dependent”.

The SFY 2004-5 biennial budget granted ODJFS authority to adopt a variety cost containment measures, including suspending new applications. In the SFY 2006-2007 biennial budget, funding was cut significantly:

SFY 2004	\$77 million	SFY 2006	\$36 million
SFY 2005	\$71 million	SFY 2007	\$25 million

As a part of the 06-07 budget, the Disability Medical Assistance Council was created. The Council reviewed the DMA program and made recommendations for changing the

¹ In Ohio, in order to be eligible for Medicaid, a person must be a child in a family with income below 200% FPL, a pregnant women with income below 150% FPL, a parent with income below 90% FPL, or must be “aged, blind or disabled”. The Bureau of Disability Determination reviews applications to determine whether a person has a disability that meets the Social Security Administration’s guidelines.

program, including implementing a more restrictive formulary for prescription drugs to reduce costs. This formulary has not been implemented.

What does it mean to be “medication dependent”?

“Medication dependency” means a licensed physician has certified that the individual has a chronic medical condition that requires continuous medication for a long-term, indefinite period of time. The documentation must also specify that if the prescription is unavailable it could increase the likelihood of experiencing a medical emergency and risk the individual’s employability for at least 9 months.

How much would it cost to re-open DMA?

- ODJFS estimates that only 3,000 people will remain on DMA as of July 1, 2007. If program enrollment was re-opened this number would gradually increase, but would probably not peak until 2009.
- If a more restrictive formulary was used, prescription drug costs, which account for 70% of the program costs, could be reduced by 21%. The estimated cost of the program would be \$39.5 million in SFY 2008 and \$104 million in SFY 2009.
- A portion of this would be recouped by the State because Medicaid could be “backbilled” for services provided to people on DMA who later are found eligible for Medicaid.

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Legislative Request: Roll Back Out-Of-Pocket Costs for Low-Income People In Public Health Care Programs

In recent years, lawmakers have sought to require people on Medicaid and other public programs to pay part of their health care costs. While shared responsibility for health care costs is important, most Medicaid beneficiaries live in poverty and have little or no ability to pay for their health care. Studies show that imposing “cost-sharing” on Medicaid beneficiaries leads to undesirable consequences.

What is “cost-sharing”?

Cost-sharing refers to the amount of money an insured person pays out-of-pocket for health care. As with private insurance, there are several forms of Medicaid cost-sharing. The most common are: a premium, usually an annual payment, to obtain coverage; a “co-pay” or fee for using a particular service, such as a doctor’s visit or prescription; or not covering certain services, in which case the person pays the full charge for the service.

For years States with Medicaid waivers have experimented with imposing greater cost-sharing on higher-income Medicaid users. In the Deficit Reduction Act of 2006, the federal government gave states flexibility to impose greater cost-sharing on Medicaid beneficiaries without getting federal approval. Proponents believe that cost-sharing promotes greater responsibility on the part of consumers: people become more cost-conscious if benefits are not “free.” Others observe that many people perceive “free” services as inferior and want to contribute something, however small.

What do the studies say about the impact of cost sharing on Medicaid users?

Most people on Medicaid have incomes *below* the poverty level (\$16,600 a year for a family of three in 2006). Research shows that even modest co-payments tend to cause low-income people to decrease their use of health care, even essential care, and can lead to use of more expensive care such as emergency room care or hospitalization.²

Research indicates that higher co-payments make it harder for Medicaid recipients to afford medical services they need, while premiums make it more difficult for low-income people to enroll and maintain coverage. Those with chronic health conditions are the most vulnerable to harm from cost-sharing, as they use the most health care services.³

The RAND Health Insurance Experiment, the definitive study of this issue, found that co-payments lead to a larger reduction in the use of medical care by low-income adults and children (below 200% poverty) than by those with higher incomes. Among low-income adults and children, health status was considerably worse for those who faced co-payments than for those who did not.⁴

² Ku, Leighton, and Victoria Wachino, “The Effect of Increased Cost-Sharing in Medicaid: Summary of Research Findings,” Center for Budget and Policy Priorities, revised 7/7/05, www.cbpp.org

³ Ku et al, *ibid*.

⁴ Ku, *ibid*, page 2,

Another research study, published in the Journal of the American Medical Association, measured the consequences of a policy change in Quebec. Researchers found that after prescription drug co-payments were added, low-income adults filled fewer prescriptions for essential medications. Co-payments led to a 78% increase in occurrence of adverse events (death, hospitalization and nursing home admissions), and to an 88% increase in emergency room use.⁵ Thus, co-payments drive up health care spending.

Even “minimal” co-pays can have serious consequences for low-income people.

Physicians at Minneapolis’ main public hospital surveyed patients attending medical clinics in mid-2004. Of 62 patients covered by Medicaid or medical assistance, more than half (32) reported an inability to get their prescriptions at least once in the last six months because of co-payments (\$3 for brand name drugs and \$1 for generic drugs). Eleven of those patients had 27 subsequent emergency room visits and hospital admissions for related disorders.⁶

Utah’s imposition of small co-payments (\$2 or \$3 per service or prescription) for below-poverty Medicaid beneficiaries led to a significant reduction in health care access and utilization. Four of ten affected Utahans reported the co-payments caused “serious” financial hardships and barriers to accessing necessary services. Another 40% reported coping strategies such as reducing the amount they spent on food or housing or “stretching out” their prescriptions (i.e., taking them less often than prescribed). Larger co-payments would impose greater hardships.⁷

Cost-sharing also has negative impacts on health care providers. Health care providers experience a loss of revenue when beneficiaries cannot afford their co-payments. They also lose revenue when beneficiaries who cannot pay premiums lose eligibility and then obtain care for which they cannot pay (uncompensated care).

SOLUTION: Roll back out-of-pocket costs for low-income people in public health care programs: As research shows, even modest cost-sharing causes some Medicaid beneficiaries to go without needed care, leading to more costly treatment down the line.

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⁵ Ku, *ibid*, page 2, citing Robyn Tamblyn, et al., “Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons,” *Journal of the American Medical Association*, 285(4): 421-429, January 2001. In this study, the low-income people were adults who were on welfare.

⁶ Ku, page 3, citing Melody Mendiola, Kevin Larsen, et al. “Medicaid Patients Perceive Copays as a Barrier to Medication Compliance,” Hennepin County Medical Center, Minneapolis, MN, presented at the Society of General Internal Medicine national conference, May 2005 and American College of Physicians Minnesota chapter conference, Nov. 2004.

⁷ Ku, citing Leighton Ku, Elaine Deschamps and Judi Hilman “The Effects Of Copayments in the Use of Medical Services and Prescription Drugs in Utah’s Medicaid Program,” Center on Budget and Policy Priorities, November 24, 2004.