

Medicaid Requires Personal Responsibility

Ohio Medicaid provides health care coverage for very low-income individuals who otherwise would be uninsured. Some require ongoing assistance related to a disability or other health condition that prevents work. But for many, Medicaid meets a temporary need as they work to move up and out of poverty. The Kasich Administration supports an individual's personal journey to self-sufficiency by encouraging personal responsibility through the following Medicaid program requirements:

- ***Require most Medicaid enrollees to get coverage through private health plans.*** Over the past four years, the Kasich Administration has enrolled additional populations in private managed care organizations, not the old government-run fee-for-service system. Today, nearly 4 of every 5 individuals on Medicaid receive coverage through a private health plan. These individuals also select the plan that they feel best serves their health care needs. The plans then coordinate care and encourage enrollees to take greater responsibility in their care. As a result of these and other cost saving measures, next year Medicaid is expected to grow less than 3 percent per member per month.
- ***Require copayments.*** Under current Ohio Medicaid rules, beneficiaries are required to pay a set amount for dental visits (\$3), vision services (\$1-2), prescriptions (\$2-3), and non-emergency emergency department visits (\$3). If an individual on Medicaid does not comply with the copayment requirement, then the provider still must provide the service at hand but may treat the delinquent copay as a debt and decline to provide services in the future. Pregnant women, children, and individuals receiving care in nursing facilities, intermediate care facilities, and hospice are not subject to copay.
- ***Require enrollees to keep information current, and redetermine eligibility annually.*** Federal law requires Medicaid recipients to make timely and accurate reports of any change in circumstances that may affect their eligibility, including home address, income, and household data; and requires state Medicaid programs to use individual's information to "redetermine" eligibility every 12 months (42 CFR 435.916). However, 42 CFR 435.603 prohibited states from performing Medicaid eligibility redeterminations for the first three months of 2014 for people in the new modified adjusted gross income (MAGI) group. Additionally, Ohio Medicaid was granted a nine month waiver of redetermination while it implemented the new *Ohio Benefits* eligibility system, which has now expired and Ohio is required to restart the redetermination process. In December 2014, Ohio Medicaid mailed redetermination packets for 170,000 Medicaid recipients whose redetermination dates were in

January, and then followed that with a reminder and, for those who did not update their information, a notice of termination. The third and final notice made it clear that failing to complete the redetermination process by January 31 would result in disenrollment from Medicaid effective February 28, 2015. Ohio Medicaid provided county job and family services offices until February 6 to process packets sent to them. As a result, an estimated 65,000 individuals (38 percent of those subject to redetermination in January) face disenrollment from Medicaid if they do not update their information (although the deadline has passed, if the individual facing disenrollment goes to a county JFS office with their documents, a county worker can rescind the termination of coverage). This process repeats monthly.

In addition, Governor Kasich's *Blueprint for a New Ohio* proposes the following additional requirements to encourage personal responsibility in the Medicaid program:

- **Assess premiums for adults above 100 percent of poverty.** Premiums are the norm for private insurance and coverage on the federal marketplace exchange, and should be for Medicaid also. The Executive Budget will require individuals in the Medicaid expansion group who are not disabled and have income above 100 percent of poverty (\$973 monthly for an individual) to pay a monthly premium to the Medicaid program. An estimated 100,000 Medicaid enrollees (less than three percent of total monthly enrollment) will be assessed premiums. Monthly premium payment amounts will be calculated similar to premiums on the exchange, approximately \$20 per month for individuals in this income range, and capped to not exceed two percent of household income. If an individual fails to pay the premium two months in a row, then Ohio Medicaid may disenroll them from the program, but then will reinstate coverage if premium payments recommence. Other states (most recently Pennsylvania, Michigan, and Iowa) enacted similar policies with federal approval under Section 1115 of the Social Security Act, and Ohio will seek the same.
- **Speed up the transition off Medicaid.** Currently in Ohio, when a parent or caretaker relative's earned income increases above the eligibility threshold for the group (206 percent of poverty for children and 90 percent of poverty for parents and caretakers), a 12-month Transitional Medical Assistance (TMA) span is approved without requiring individuals to complete quarterly reporting of their income. The Executive Budget will return this eligibility policy to a pre-recession policy that requires quarterly reporting for anyone whose income increases above the allowable threshold and, as long as the person's income remains below 185 percent of poverty, provides twelve months of continued Medicaid eligibility. If the person does not report their income, in the second or subsequent quarters, their eligibility will end at the end of that quarter. The six to twelve month transitional assistance provides

time for the individual to seek subsidized coverage on the exchange or other private insurance.

- ***Eliminate Medicaid coverage for adults at higher income levels.*** Because subsidized health insurance is now available on the federal marketplace exchange, the Executive Budget will eliminate Medicaid coverage above 138 percent modified adjusted gross income (MAGI) for pregnant women, the Breast and Cervical Cancer Program (BCCP), and the Family Planning Group. Currently, individuals in these groups are eligible for Medicaid up to 200 percent of poverty, but those levels were set when the federal exchange did not exist and the only alternative to Medicaid was to be uninsured. Ohioans enrolled through the pregnant women and BCCP eligibility groups at the time of the change will be allowed to continue to receive services through Medicaid until their eligibility expires under current rules. Individuals with eligibility in the Family Planning Group with income below 138 percent MAGI can obtain full Medicaid coverage instead of the limited benefit, and those above 138 percent MAGI can obtain subsidized coverage through the marketplace exchange. This provision does not apply to persons at higher incomes who qualify for Medicaid through Medicaid Buy-In for Workers with Disabilities or because they need long-term care services (these groups require services available through Medicaid but not necessarily covered by plans on the exchange).