Healthy Ohio Program

- Ohio Medicaid provides health care coverage for low-income individuals. 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. Ohio Medicaid encourages personal responsibility for these individuals by requiring them to enroll in private-sector health plans, pay copayments, keep personal information current, and redetermine eligibility every year.

- In February 2015, Governor Kasich proposed to assess premiums for adults in the Medicaid expansion group who are not disabled and have income above 100 percent of poverty. Premiums are the norm for private insurance and coverage on the federal marketplace exchange. Ohio Medicaid proposed to calculate monthly premiums similar to premiums on the exchange, approximately $20 per month, and capped not to exceed two percent of household income. Other states have enacted similar policies with federal approval.

- During consideration of the budget, the Ohio House proposed and the Senate agreed to replace the Administration's premium proposal with a new *Healthy Ohio Program*. The legislature's plan requires Medicaid to seek a federal waiver to mandate enrollment in a Health Savings Account (HSA) for every non-disabled adult enrolled in Medicaid regardless of income. Each *Healthy Ohio* enrollee would be required to deposit two percent of family income up to a $99 annual limit into an HSA administered by their health plan, and the Ohio Medicaid program would be required to deposit an additional $1,000 annually into each person's account. *Healthy Ohio* enrollees also would be subject to copayments, but only if there is a balance in their HSA. Health plans would not be allowed to pay for any service for a *Healthy Ohio* enrollee until the individual's HSA is depleted.

- At several points during the process, the Administration cautioned legislators that the House plan, as proposed, includes provisions that to date have not been approved by the federal government. For example, no state has received federal approval to terminate a person's Medicaid eligibility for not paying premiums or contributions to a health savings account for Medicaid enrollees with income below 100 percent of poverty. Only one state (Indiana) has received federal approval to test HSAs in Medicaid, but the Indiana waiver does not go as far as the Ohio House proposal to terminate Medicaid eligibility for people below 100 percent of poverty if they fail to contribute.

- Ohio Medicaid will seek a federal waiver in 2016 to implement *Healthy Ohio*. Ohio Medicaid will post the draft waiver request on April 15, 2016, invite public comment on the draft from April 15 to May 13 including two public hearings, consider making changes based on public comment, and submit the final request to the Centers for Medicare & Medicaid Services (CMS) not later than June 30, 2016. CMS will post Ohio's request online for at least 30 days and wait at least 45 days after submission before making a decision. There is no deadline for CMS to respond to the state, but six to nine months is normal.

updated April 7, 2016