pb

policy brief

FAMILIES AT RISK:

IMPOSING PREMIUMS ON LOW-INCOME ELDERLY AND DISABLED PERSONS IN MEDICAID

SUMMARY

The Connecticut Department of Social Services (DSS) has announced plans to charge premiums to almost 30,000 low-income elderly and disabled Connecticut residents for their public health care coverage. Because some of these individuals may be protected by federal law, there are questions about the Department's ability to impose these premiums. However, if charges are imposed as planned, almost one quarter of these individuals — over 7,000 — will lose Medicaid coverage for the health care services they need, because they cannot afford to pay the premiums.

Key findings of this brief include:

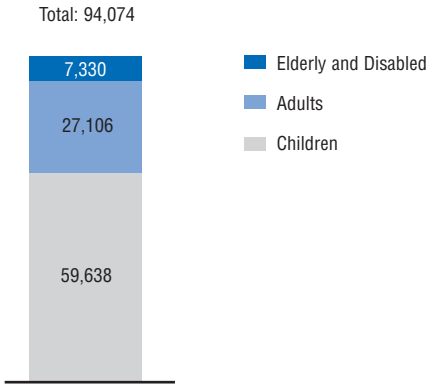
- Nearly 25 percent or 7,330 elderly and disabled persons can be expected to lose Medicaid coverage if premiums are implemented as DSS has announced.[1] Premiums imposed will range from $11 to $14 a month and will affect persons whose incomes already fall below the poverty line.
- The elderly and persons with disabilities with the lowest incomes and the least ability to pay will be the most severely affected by the Department's proposal.
- Because of complex eligibility rules, assessing who will be charged premiums and tracking premium payments will be administratively burdensome to DSS.

BACKGROUND: STATE IMPOSES PREMIUMS

The first paper in this series showed that imposing premiums on low-income families in Connecticut's HUSKY A program is expected to cause more than 86,000 children and parents to lose coverage. At the same time that the General Assembly passed legislation requiring premiums in HUSKY A, it also directed DSS to charge premiums for other individuals covered by Medicaid. As a result, DSS is now working on a plan to charge premiums to a group of elderly and disabled individuals known as the "medically needy" beginning in April 2004. Unlike families in HUSKY A, these Medicaid beneficiaries can be charged premiums without a waiver of federal law, so the state can implement this change more quickly.

...an estimated 7,330 elderly and disabled individuals can be expected to lose coverage because they will not be able to afford the premiums.

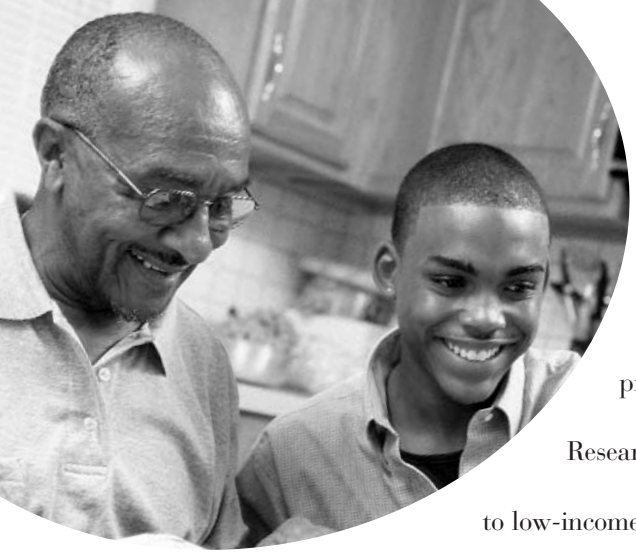
Over 94,000 Persons Could Lose Coverage if Premiums are Adopted



Source: Georgetown University Health Policy Institute Analysis.

Connecticut Health Foundation

THE ANTHEM FOUNDATION OF CONNECTICUT, INC.



IMPOSING PREMIUMS RESULTS IN LOSS OF COVERAGE

Almost 30,000 elderly and disabled Connecticut residents will be charged premiums of about $11 to $14 a month depending on their monthly incomes. Research findings and recent experiences in other states show that charging premiums to low-income persons results in a decline in enrollment in public health programs.

Earlier this year, Oregon imposed and increased premiums on individuals in its Medicaid program. As of September 2003, the state reports that 32,000 individuals had disenrolled from the state's Medicaid program because they were unable to pay the premiums.[2]

When a model developed by Urban Institute researchers is applied to Connecticut's "medically needy" population to determine the likely impact of these premiums on program participation, the result is that an estimated 7,330 elderly and disabled individuals can be expected to lose coverage because they will not be able to afford the premiums.[3]

DEFINING "MEDICALLY NEEDY"

The Medicaid program provides a variety of pathways to coverage for elderly and disabled individuals, making the determination of eligibility quite complex. In order to participate in the federal Medicaid program, states must provide coverage to certain groups of individuals ("mandatory" coverage groups). Beyond that requirement, states have a number of choices for providing coverage. One of these optional categories is the "medically needy." In most states, those eligible for Medicaid as medically needy are people whose income is above Medicaid's financial eligibility standards, but who have high medical expenses.[4]

In Connecticut there are actually two ways to become eligible for the medically needy category. The larger group of medically needy individuals, known as those with "zero spend-downs," will be far more severely affected by the premiums.[5] Unlike those individuals who deduct their medical expenses to become eligible for Medicaid, these persons have lower incomes that do not exceed Medicaid's financial eligibility standards. As a result they are eligible for Medicaid without consideration of their medical expenses.[6]

Premiums on the Medically Needy in Connecticut will Vary According to Geographic Regions

Region	Annual Income	Monthly Income	Monthly Premium	Premium as % of Income
Region A*	$9,096	$758	$14	1.8%
Region B and C	$7,908	$659	$12	1.8%

*Region A includes: Bethel, Bridgewater, Brookfield, Danbury, Darien, Greenwich, New Canaan, New Fairfield, New Milford, Newtown, Norwalk, Redding, Ridgefield, Roxbury, Sherman, Stamford, Washington, Weston, Westport, and Wilton. All remaining towns and cities are in Regions B and C.

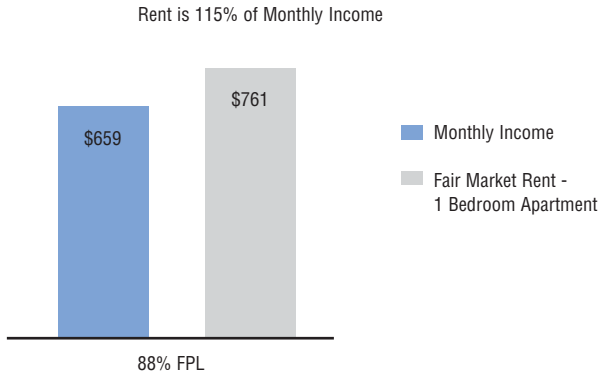
In October 2003, the total enrollment of persons in Connecticut's medically needy program was 29,576.[7] Of this total, 25,045 elderly and disabled Connecticut residents with incomes below the federal poverty level were in the medically needy "zero spend-down" category. The incomes of these individuals range from $7,908 to $9,096 per year, or $659 to $758 per month, depending on where they live.[8] These low-income seniors and persons with disabilities will have to pay the premiums from their Social Security or pension income, which is already at or below the poverty level.

SEVEREST IMPACT ON THOSE WITH LOWEST INCOMES

The individuals who will soon be charged premiums are living on fixed incomes such as Social Security benefits or other pensions, with most having incomes below $8,000 a year — less than the federal poverty level of $8,980 for a family of one. Because they are over 65 or disabled, they are likely to have chronic medical conditions and ongoing medical needs. As a result of recent changes to Medicaid they are also now charged $2 for each medical visit and $1.50 for each prescription. Federal Medicaid regulations permit states to charge medically needy individuals premiums of approximately 1.8 percent of their monthly income. However, most states do not have significant numbers of individuals in the "zero spend-down" category, so imposing premiums on the medically needy does not affect the monthly budgets of low-income beneficiaries as severely in other states as in Connecticut.

The expenses of persons living on fixed incomes are already high. For example, the average rental price for a one-bedroom apartment in New Haven is $761 a month, 115 percent of the monthly income of New Haven residents who will soon be charged premiums.[9] Given the most basic costs of food, utilities, and out-of-pocket medical expenses in addition to housing, many of these elderly and disabled individuals will not be able to afford Medicaid premiums. While some may be eligible for Medicare, Medicaid provides a critical supplementation to Medicare, including prescription drug coverage, long-term care services and assistance with Medicare cost-sharing which can be unaffordable for low-income persons.[10]

Average Rental Prices for 1-Bedroom Apartments in the New Haven Area



Note: Housing is considered affordable if it costs no more than 30 percent of the renter's income. The medically needy income eligibility level in Regions B and C in Connecticut is $659.

Source: Based on 2004 Fair Market Rents for 1-Bedroom Apartments in the New Haven region, from the Federal Department of Housing and Urban Development, October 2003. Available online: www.huduser.org/Datastes/FMR/FMR2004F/CT_FY2004F.pdf.

LOSS OF COVERAGE MEANS SERIOUS MEDICAL CONSEQUENCES

Individuals who lose Medicaid will be without coverage for prescription drugs and are unlikely to be able to afford them on their own.[11] A study of seniors in Quebec found that the use of "essential" drugs by the elderly decreased by 9 percent after cost sharing was implemented, leading to a significant increase in the use of the emergency room and serious consequences including hospitalization and death.[12] Lack of prescription drug coverage has a particularly severe impact on seniors and persons with disabilities, and will result in higher costs when they seek treatment after going without needed prescriptions or other health care services.[13]

Because uninsured individuals with chronic conditions such as diabetes and cardiovascular disease are less likely to receive appropriate care to manage their conditions, their health outcomes are worse than those of insured persons. Numerous studies have shown that individuals who lose health coverage experience declines in their health status.[14]

ARE ALL THE INDIVIDUALS WHO WILL BE CHARGED PREMIUMS ACTUALLY MEDICALLY NEEDY?

Only individuals who are medically needy can be charged premiums unless the state obtains a waiver of federal law. Because of their low incomes and the complex eligibility rules that govern Medicaid, many of the over 25,000 individuals in the zero spend-down group are likely to be eligible through other coverage groups that cannot be charged premiums. Before charging premiums that could cause them to lose coverage, DSS will have to examine the circumstances of each of the 25,045 affected individuals to make sure they are correctly classified and are not inappropriately charged premiums.

CONCLUSION: A COSTLY POLICY FOR EVERYONE

Charging premiums to the elderly and disabled who rely on Medicaid for essential health care is likely to cause a significant number of them to lose Medicaid coverage. Many will become uninsured; others will lose access to critical services like prescription drugs.

- Nearly 25 percent or 7,330 elderly and disabled persons can be expected to lose Medicaid coverage if premiums are implemented as the Department has announced.[15] Premiums imposed will range from $11 to $14 a month and will affect persons whose incomes already fall below the poverty line.
- The elderly and persons with disabilities with the lowest incomes and the least ability to pay will be the most severely affected by the Department's proposal.
- Because of complex eligibility rules, assessing who will be charged premiums and tracking premium payments will be administratively burdensome for DSS.

REFERENCES

1 Georgetown Health Policy Institute analysis based on model developed by Ku and Coughlin. See the Methodology section for more details.

2 Mann C, Artiga S and Guyer J. *Assessing the Role of Recent Waivers in Providing New Coverage* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, December 2003), p. 4.

3 Georgetown Health Policy Institute analysis based on model developed by Ku and Coughlin. See the Methodology section for more details.

4 Crowley, J. *Medicaid Medically Needy Programs: An Important Source of Medicaid Coverage* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, January 2003)

5 Individuals in the smaller group have incomes above the medically needy income level but have high medical expenses. As of October 2003, there were 4,531 persons in this category. These individuals can "spend down" to the state's medically needy income limit (MNIL) by deducting medical expenses from their income. In most of Connecticut, the MNIL is $476 per month, but before comparing an elderly or disabled individual's monthly income to the MNIL, $183 of monthly income is deducted, making the actual limit $659 in most of the state. The elderly and disabled Connecticut residents who are in the spend-down category will soon have to pay monthly premiums to continue their Medicaid coverage, but the premiums will be counted as medical expenses when their eligibility for Medicaid is determined. Thus, the premiums will not have an impact on their monthly budgets, because they will be counted as a medical expense.

6 How an individual is classified as being in the medically needy zero spend-down group is very complex. The group includes two basic sub-groups of people – those whose incomes fall above the income requirements for mandatory Medicaid coverage but below the medically needy income level in Region A of the state, and those who live in shared housing or have very low rents.

7 Connecticut Department of Social Services Report DMF8040A-DMF80261 (October 31, 2003). This figure does not include an additional 2,234 individuals in long-term care facilities who will not be charged premiums.

8 Unlike most states, Connecticut cash benefit levels and Medicaid medically needy income levels vary by region.

9 Georgetown Health Policy Institute analysis based on federal Fair Market Rent data available at 68 Federal Register 56713 (October 1, 2003).

10 The new Medicare prescription drug benefit does not become available until 2006. Its adequacy for low-income persons is unclear. For more information on dual eligibles, see Brian Bruen and John Holahan *Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, November 2003).

11 For more information on the impact of cost-sharing, see Hudman J. and O'Malley M. *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, March 2003)

12 Robyn Tamblyn et al. "Adverse Events Associated with Prescription Drug Cost Sharing Among Poor and Elderly Persons," *JAMA* 285, no. 4 (January 24/31, 2001): 421-429.

13 See Leighton Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid* (Washington, D.C.: Center on Budget and Policy Priorities, May 7, 2003), which summarizes studies on the effect of premiums and co-payments on health care status and utilization of services.

14 Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington, D.C.: National Academy Press, 2002).

15 Georgetown Health Policy Institute analysis based on model developed by Ku and Coughlin. See the Methodology section for more details.

METHODOLOGY

Georgetown University Health Policy Institute estimates are based on the following model developed by Ku and Coughlin to determine the expected participation as a function of premium cost.

(P/1-P) =.7239 - .4555X
P = the estimated participation rate for an income cohort
X = the premium level as a percentage of income

(See Ku and Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," Inquiry 36:471-480 Winter 1999/2000)

The premium level as a percentage of income (X) that will be charged to medically needy individuals is 1.8 percent of gross income for all participants because this is the maximum permissible under federal regulation. We applied the resulting estimated participation rate (P) to October 2003 state enrollment data.

Monette Goodrich,
Connecticut Health Foundation
Editor

Joan Alker,
Health Policy Institute,
Georgetown University
Co-author

Judith Solomon,
Connecticut Voices for Children
Co-author

If you would like a copy of our policy brief, contact Monette Goodrich at monette@cthealth.org or at 860.409.7773.

Connecticut Health Foundation

270 Farmington Avenue, Suite 357
Farmington, CT 06032
www.cthealth.org

Non-Profit
US Postage
PAID
E. Hampton, CT
Permit No 7