Connecticut Health
FOUNDATION

Policy Brief

Proposed Medicaid Cost Sharing: Evaluating The Impact

April 2009
Proposed Medicaid changes: First in a series

IN SUMMARY

- **Proposed new and increased HUSKY premiums could cost the state $1.3 billion in new federal Medicaid funding — far more than $21 million in projected savings — because the federal stimulus law requires maintaining eligibility standards.**
- **Imposing Medicaid premiums risks losing coverage for:**
    - **Nearly half — 8,000 of about 18,000 — of HUSKY A parents likely to face new premiums**
    - **About one in three — 1,600 of 5,000 — of HUSKY B children whose premiums could increase**
- **Research shows enrollment fell when other states increased premiums, resulting in more uninsured.**
- **Copayments on prescription drugs and other services save money at the expense of increasing costs for families and providers, causing individuals to stop taking medications.**

OVERVIEW

Recent 2010-2011 fiscal year budget proposals to impose new cost sharing on certain children and adults covered by Connecticut's Medicaid program for children and parents (HUSKY) may result in some failing to obtain needed health care. Others may lose coverage entirely.

More significant, instead of saving over $21 million from new and increased premiums, Connecticut could lose $1.3 billion in new federal Medicaid matching funds. This stems from the federal stimulus requirement that states maintain their current Medicaid eligibility levels to obtain stimulus dollars.

New or increased premiums could lead about 10,000 parents and children to drop HUSKY coverage. And new copayments on health care services threaten access by making it harder for individuals to obtain appropriate services. The state may achieve short-term savings, but at the cost of limiting access to preventive care and other services.

These are just some potential consequences of policy-makers' attempts to address the state's projected biennial budget deficit of $6 billion to $8 billion. But answering the challenge in this way eliminates the opportunity to receive additional federal Medicaid funding from the federal stimulus.

ABOUT HUSKY

HUSKY provides health insurance for nearly 350,000 Connecticut children and parents.

- HUSKY A is Connecticut's Medicaid program for low-income families.
- HUSKY B is the state's Children's Health Insurance Program (CHIP) for children in families with incomes too high to qualify for HUSKY A.

Federal matching funds cover 50 percent of HUSKY A costs and 65 percent of HUSKY B. The HUSKY A matching rate increases temporarily to at least 60 percent under federal stimulus legislation.

For more information, see "HUSKY At a Glance," Connecticut Voices for Children, February 2009.

SAVINGS OR LOSS?

Governor M. Jodi Rell's two-year budget proposes new and increased premiums and copayments for certain HUSKY beneficiaries (Exhibit 1). She offered these measures believing they would preclude cutbacks in the program's eligibility levels.[1]

In fact, new or higher premiums violate the federal stimulus requirement that states maintain current eligibility standards to receive higher federal Medicaid matching funds.[2]

Connecticut is eligible for over $1.3 billion in new federal dollars (more if unemployment rises higher than expected).[3] Clearly, this dwarfs the $21 million in estimated savings associated with new and higher premiums.

Exhibit 1: Proposed Cost Sharing

Children below 100 percent ($18,310 for a family of three) of the federal poverty level (133 percent or $24,352, family of three, for those under age six):

- No premiums
- New copayments may be charged for non-emergency use of the emergency room and for non-preferred drugs

Children in HUSKY A (Medicaid) at higher income levels:

- No premiums
- New copayments for a variety of services

Children in HUSKY B (CHIP) with incomes between 236 percent and 300 percent of poverty (between $43,029 and $54,930 for a family of three):

- Premiums increased to $50 to $100 per month (up from $30 to $50 per month), depending on family size
- Copayments remained unchanged

Parents in HUSKY A (Medicaid) below 150 percent of poverty ($27,465 for a family of three):

- No premiums
- New copayments for a variety of services

Parents in HUSKY A (Medicaid) from 150 percent to 185 percent ($33,874 for a family of three) of poverty:*

- New premiums (unknown amount)
- Higher copayments for a variety of services

**Parents with incomes over 185 percent of poverty are generally not eligible for HUSKY A.*
NOTE: This compilation is based on the best information available. Not all details are specified in the governor's budget.

New or increased premiums could lead about 10,000 parents and children to drop HUSKY coverage.

COST SHARING AND FAMILY BUDGETS

Even with Medicaid's help, health expenses for low-income families represent a substantially larger share of their income than for those with higher incomes.[4]

At 175 percent of the federal poverty level (FPL) (typical for parents who may be required to pay new premiums), a family of three has an annual income of about $32,000. With Connecticut's high cost of living, these families struggle to make ends meet.

In Connecticut, the average monthly rent for a two-bedroom apartment ($1,098) equals about 40 percent of the family's income.[5] This family's income is not enough to cover rent, food, child care and taxes, let alone health costs.[6]

IMPACT OF NEW AND INCREASED PREMIUMS

Using authority from a 2005 federal law, the governor's proposal would add premiums for about 18,000 HUSKY A adult enrollees with incomes above $27,465.[7] It also would increase premiums for nearly 5,000 HUSKY B children.[8]

RESULTS IN OTHER STATES

Research, based on at least 11 states, shows new or increased premiums led to lower Medicaid or CHIP enrollment. Examples include:

- Missouri - A 30-percent enrollment decrease over two years followed new premiums in 2005.[10]
- Maryland - About 28 percent of children disenrolled in a year when some were charged $37 in monthly premiums.[11]
- Oregon - Premiums for adults with incomes below poverty level led to enrollment dropping from 100,000 to 30,000.[12]

Considerable research over the past decade shows that when states added or increased premiums, loss of enrollment resulted. In addition, studies using national survey data show similar findings.[9]

While some of those losing public coverage may obtain private insurance, many — especially at lower incomes — remain without insurance.

In 1999/2000, Urban Institute researchers studying three states found higher premiums as a percentage of income are related to lower Medicaid participation by those without insurance.[13] Applying this model to Connecticut's proposal suggests nearly 10,000 parents and children likely will lose coverage.[14]

- About 8,000 parents — nearly half the approximately 18,000 HUSKY A enrollees expected to face new premiums — might drop Medicaid and become uninsured.
- About 1,600 children — one in three — of the nearly 5,000 HUSKY B children whose premiums would increase are likely to drop coverage.

FOOTNOTES

1 FY 2010-FY 2011 Biennium: Governor's Budget Summary, p. 16.

2 The stimulus legislation, the American Recovery And Reinvestment Act (AARA), includes a "maintenance of effort" requirement for states to receive the higher matching funds that are part of the stimulus. Guidelines from the federal government confirm that new or increased premiums would fail this requirement.

3 "The Federal Stimulus Package and passage of the SCHIP bill: How much health care help can CT expect?" Connecticut Health Policy Project, February 16, 2009, revised March 4, 2009; "American Recovery And Reinvestment Act (AARA) Of 2009: State-by-State Estimates of Key Provisions Affecting Low- and Moderate-Income Individuals," Center for Budget and Policy Priorities, March 3, 2009.

4 On average, low-income adults paid $210 out of pocket (2.4 percent of income) in 2002; those at higher income levels with private insurance paid an average of $548 out of pocket (0.7 percent of income). These expenses include copayments for drugs and other services, as well as costs for services not covered under Medicaid. Leighton Ku and Matthew Broaddus, "Out-of-Pocket Medical Expenses for Medicaid Beneficiaries are Substantial and Growing," Center for Budget and Policy Priorities, May 2005.

5 *Out of Reach 2007-2008*, National Low Income Housing Coalition, Washington, D.C.

6 A 2005 estimate of the cost of self-sufficiency for a family of three in Hartford was $3,714 monthly or over $44,000 annually. This calculation includes housing, child care, food, transportation, health care, and taxes (include tax credits for child care). Dana Pearce, *The Real Cost of Living in 2005: The Self-Sufficiency Standard for Connecticut* (Wider Opportunities for Women and Office of Workplace Competitiveness, State of Connecticut, 2005).

7 The estimate of 18,000 parents facing new premiums is based on data obtained from the state. It most likely includes some pregnant women, who would not be charged premiums under the proposal.

8 The governor proposes to impose cost sharing within the limits of amounts allowed under the Deficit Reduction Act of 2005 (DRA). This law limits premiums for parents with incomes over 150 percent of the federal poverty level or about $26,400 for a family of three. The increased premiums for children apply to families with incomes between about $41,360 and $52,800 (based also on a family of three).

9 Genevieve Kenney, Jack Hadley and Fredric Blavin, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003," *Inquiry* 43(4): 345-361, Winter 2006/2007; Jack Hadley et al., "Insurance Premiums and Insurance Coverage of Near-Poor Children," *Inquiry* 43(4): 362-377, Winter 2006/2007.

PREMIUM DESIGN MAKES A DIFFERENCE

The possibility that children and parents will be unable to pay new HUSKY premiums will be even higher under certain policies.[15]

In HUSKY B today, nonpayment locks out a child for three months until the family pays the missing premiums and prepays the next. This heightens the difficulty facing a family struggling just to pay for rent and groceries. (For children who pay premiums, some help is available through a CHIP Reauthorization Act policy that states must provide a 30-day premium grace period in case of nonpayment.)

Even if some families eventually catch up with premium payments, the resulting cycling on and off coverage also can add to state administrative costs. Moreover, substantial disenrollment leads to more uninsured individuals. This increases uncompensated care and accompanying costs throughout the health system.

- Physicians and hospitals treating patients who cannot pay will either bear part of this burden in reduced revenue or shift some costs to private payers.
- Other state safety-net programs may incur added costs, as well — costs that may not earn federal matching funds.

Exhibit 2: Maximum Allowable Copays under the Deficit Reduction Act

Total premiums and copays may not exceed 5 percent of family income.

	Mandatory Medicaid Children	Other Medicaid Children 100%-150% FPL	Medicaid Children 150% FPL or higher	Medicaid Parents under 100% FPL	Medicaid Parents 100%-150% FPL	Medicaid Parents 150% FPL or higher
Preventive Services	No copay allowed	No copay allowed	No copay allowed	$3.40 or 5% of payment	$3.40 or 10% of payment	$3.40 or 20% of payment
Outpatient Services	No copay allowed	10% of payment	20% of payment	Up to $3.40 or 5% of payment	$3.40 or 10% of payment	$3.40 or 20% of payment
Prescription Drugs	$3.40 or 5% of payment (non-preferred drugs only)	$3.40 or 5% of payment	$3.40 or 5% of payment; 20% for non-preferred drugs	$3.40 or 5% of payment	$3.40 or 5% of payment	$3.40 or 5% of payment; 20% for non-preferred drugs
Non-emergency Use of the ER	$3.40 or 5% of payment	$6.80 or 5% of payment	No limit	$3.40 or 5% of payment	$6.80 or 5% of payment	No limit

NOTES: Mandatory Medicaid children are those under age six with family income below 133 percent of the FPL and those ages 6 to 17 with family income below 100 percent of the FPL. Payment refers to provider's charge or fee allowed by the state.

SOURCE: Adapted from "Cost Sharing for Children and Families in Medicaid and SCHIP," Center for Children and Families, Georgetown University, September 2008.

THE IMPACT OF COPAYMENTS ON FAMILIES

Health care access is threatened if copayments prevent individuals from obtaining appropriate services. New copayments charged when parents and children visit a doctor or pick up a prescription potentially save the state about $19 million over two years by shifting costs to families, leading some to reduce use of services. Therefore, the state may achieve short-term savings at the cost of limiting access to preventive care and other services.

Federal rules apply different limits on copayments based on eligibility and income status (Exhibit 2). Consistent with these limits, proposed copayments would likely apply to:

- Preventive services
- Certain other physician and outpatient services
- Prescription drugs
- Non-emergency use of the emergency room

(continued on page 5)

10 Stephen Zuckerman, Dawn M. Miller, and Emily Shelton Pape, "Missouri's 2005 Medicaid Cuts: How Did They Affect Enrollees And Providers?" *Health Affairs* 28 (2): w335-w345, March/April 2009.

11 Samantha Artiga and Molly O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Kaiser Commission on Medicaid and the Uninsured, May 2005; Leighton Ku, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, May 31, 2005.

12 Leighton Ku, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, May 31, 2005.

13 Leighton Ku and Teresa Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry* 36(4): 471-480, Winter 1999-2000. A rough validation of this model, based on more recently published studies of new or increased premiums, supports the general accuracy of the model, although many factors affect the specific outcomes in different states. We believe that use of the model for Connecticut is appropriate, though the estimates should be regarded as illustrating the general direction and magnitude of outcomes, not precise estimates.

14 Because Medicaid programs always experience a cycling of enrollment as health and financial circumstances shift among those potentially eligible, those projected to lose coverage are the net enrollment loss from actual disenrollments and failure of others who are potentially eligible to sign up for new coverage.

15 Genevieve Kenney et al., "Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States," *Inquiry* 43(4): 378-392, Winter 2006/2007.

16 Arleen Leibowitz et al., "Effect of Cost-Sharing on the Use of Medical Services by Children: Interim Results from a Randomized Controlled Trial," *Pediatrics* 75(5): 942-951, 1985.

17 AcademyHealth, "Surviving the Perfect Storm: Impacts of Benefit Reductions and Increased Cost Sharing in a Medicaid Program," Vol. XI, No. 4, July 2008; Neal T. Wallace et al., "How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan," *Health Services Research* 43(2): 515-530, April 2008; Bill J. Wright et al., "Impact of Changes to Premiums, Cost-Sharing, and Benefits on Adult Medicaid Beneficiaries: Results from an Ongoing Study of the Oregon Health Plan," The Commonwealth Fund, July 2005.

18 Bruce Stuart and Christopher Zacker, "Who Bears the Burden of Medicaid Drug Copayment Policies?" *Health Affairs* 18(2): 201-212, March/April 1999; Arthur A. Nelson et al., "The Effect of Medicaid Drug Copayment Program on the Utilization and Costs of Prescription Services," *Medical Care* 22: 724-736, August 1984; C.E. Reeder and Arthur A. Nelson, "The Differential Impact of Copayment on Drug Use in a Medicaid Population," *Inquiry* 22: 396-403, Winter 1985.

19 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 24/31, 2001.

20 Health Care Not Welfare Project, "It's Health Care, Not Welfare: Final Report," University of Oklahoma Health Sciences Center, submitted to the Oklahoma Health Care Authority, March 31, 2004.

RESEARCH ON COPAYMENTS IN OREGON

- Copayments added in 2003 and 2004 reduced use of covered services, but without any state savings.
- Some treatments apparently were moved to more expensive but less cost-effective settings, such as hospitals, because hospitals often do not collect copayments.
- Even aggressive copays aimed at reducing unnecessary emergency room use generated no more than a 2 percent savings.
- One-third of surveyed Oregonians with unmet needs went without needed care because of cost.[17]

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Ideally, quality might be improved and costs lowered if copayments help reduce inappropriate use of the emergency room, unnecessary visits to the doctor and use of expensive brand-name drugs instead of equivalent generics. But a major 15-year study in the 1970s and 1980s found that asking individuals to pay more reduced use of both appropriate and inappropriate services.

Low-income individuals in particular were as likely to skip needed services as inappropriate ones. Children's use of outpatient care decreased as much as 30 percent, depending on how much families were required to pay.[16] A more recent study in Oregon (see left) reinforces these findings.

Prescription drug copayments, in particular, appear to achieve savings at least in part from people forgoing needed medications.

- Studies show that when faced with copays (even 50 cents to $3, as allowed before the recent change in federal law), people on limited incomes reduced drug use.[18]
- Evidence from a Quebec study shows people are more likely to skip drugs for hypertension or other conditions where the effect, although clinically significant, was less obvious to the patient than from medications providing immediate relief.[19]
- The Quebec study also found that when people stopped taking drugs identified by researchers as "essential," use of emergency rooms, hospitals or nursing homes increased.

For conditions such as diabetes and asthma, skipping medications can have a dramatic short-term effect on one's health. Furthermore, when resulting complications lead to an emergency room visit or hospitalization, the state's cost will far exceed the savings from requiring copayments.

COPAYMENTS AFFECT PROVIDERS AS WELL AS PATIENTS

Even if copayments save Connecticut money, they also may affect providers adversely. Some providers, already concerned about low Medicaid payment rates and the administrative hassle of collecting copays, may stop treating Medicaid patients.

Medicaid has allowed "nominal" copayments for years. But providers were previously instructed that services must be delivered even if the patient could not pay. (This rule no longer applies for those with incomes over the poverty level.) When providers deliver a service without collecting a copay, their payment rates are effectively cut.

A 2004 study of Oklahoma providers (before the federal rule changes) found copayments were collected only 29 percent of the time.[20] Federal law now allows higher copayment levels — effectively a deeper cut in provider rates.

Providers already see Medicaid payment rates as inadequate. Collecting copays to maintain current payment rates and the resulting hassle will likely lead some to drop out of Medicaid.

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MORE INFORMATION

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CONCLUSION

In evaluating the proposal for new or increased premiums and copayments in Connecticut's HUSKY program, state policy-makers should consider carefully whether modest savings from these changes justify the inevitable disruption of cost-effective health care.

- Federal rules will most likely treat new premiums as an eligibility reduction, causing Connecticut to lose $1.3 billion in new Medicaid funding from the federal stimulus.
- Research on premiums applied in other states consistently shows higher premiums lead to lower enrollment.
- Applying this research to Connecticut, nearly 10,000 parents and children may drop out because they cannot afford to pay new and increased HUSKY premiums. Many will become uninsured.
- Not only will they lose Medicaid coverage, but when they seek care from emergency rooms or other safety-net providers, state costs will increase.

Policy-makers also should consider the impact of charging copayments for some outpatient services and prescription drugs.

- Although economic theory says cost sharing makes individuals more sensitive to whether a service is necessary, research suggests lower-income individuals actually forgo needed services.
- They may stop taking medications intended to prevent complications from asthma or diabetes, as well as drugs for other chronic conditions, where the impact may be less immediate, but just as serious.
- Some decisions will lead inevitably to an emergency room visit or hospitalization that could have been avoided and for which the state may have to pay.
- Providers also will be forced to collect copayments to avoid an effective reduction in reimbursements.
- Fewer providers may accept Medicaid because of increased pressure on already low Medicaid payments.

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