kaiser commission on medicaid and the uninsured

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# Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences

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## EXECUTIVE SUMMARY

Individuals in almost all private health insurance plans pay premiums and cost sharing. In contrast, the Medicaid program has historically prohibited or limited premiums and cost sharing because it serves a low-income population with very limited resources, that is generally sicker and, by definition, poorer than the population covered by private insurance. The State Children's Health Insurance Program (SCHIP), enacted in 1997, extends coverage to low-income children above Medicaid income eligibility limits and gives states the authority to impose limited premiums and cost sharing.

Over the years, as states implemented their SCHIP programs and some states expanded Medicaid coverage to relatively higher income groups, premiums and cost sharing were utilized to better align public coverage with private coverage and to encourage more personal responsibility over health care choices. This was intended to address equity issues and to prevent people from dropping private coverage to take up public coverage. Premiums and cost sharing can also serve as ways to limit or reduce state program costs to address budget shortfalls.

The impact of additional out-of-pocket costs for poor and low-income families warrants careful examination. Earlier research has demonstrated that if costs are too high and/or imposed at too low an income they can impede access to care and create financial burdens for families. Even when insured, low-income individuals already devote a substantial share of their incomes to health care costs because they pay a significant portion of their health care expenses (not including premiums) out-of-pocket. Insured low-income individuals devote about 17% of their incomes to health care, compared to 6% for higher income individuals. The average low-income privately insured individual pays 35% of his or her health care expenses out-of-pocket, and, while Medicaid appears to offer some cost protection, adult Medicaid beneficiaries still pay about 12% of their health care expenses out-of-pocket.

Over the past few years, a number of states have implemented new or increased existing out-of-pocket requirements for beneficiaries in their Medicaid, SCHIP, or other public coverage programs. This brief reviews the key findings from this recent activity. By contacting all 50 states and the District of Columbia by telephone and performing an internet search of research institutions, government websites and foundations, we identified 13 relevant studies conducted in seven states between 2001 and 2005. These studies employed a range of approaches, including examining enrollment trends using state administrative data, surveys of disenrollees, and focus groups with affected individuals and providers who serve the low-income population.

## Key Findings

### *Impact of Premiums on Enrollment*

**New or increased premiums served as a barrier to obtaining and/or maintaining public coverage**. For example, in 2003, under a Medicaid waiver, Oregon increased premiums for poor adults to $6-$20, based on income. The state also tightened premium payment policies by establishing a new lock-out period for nonpayment and eliminating premium waivers for extenuating circumstances such as lack of income or homelessness. Following these changes, enrollment dropped by nearly half or roughly 50,000 people. There were enrollment losses among all those subject to the increased premiums, but losses were steepest among those with the lowest incomes. Nearly a third (31%) of surveyed disenrollees reported premium costs as a primary reason they lost coverage. In focus groups, disenrollees cited both problems affording the premium as well as problems adhering to the strict payment policy as primary factors leading to their coverage loss.

In January 2004, Vermont increased premiums in its Medicaid waiver and SCHIP programs. During the first month of increased premiums, enrollment declined by 11% or 4,500 people. Cost was reported as the reason for disenrollment by 70% of those who lost Vermont's Health Access Plan Medicaid waiver coverage, which covers adults with incomes between 50%-185% of poverty, and 26% of those who lost SCHIP coverage, which covers children with incomes between 185%-300% of poverty.

**Premiums disproportionately impacted those with the lowest incomes, but also led to disenrollment among those with incomes above 150% of poverty.** In January 2002, under a Medicaid waiver, Rhode Island began charging families with incomes above 150% of poverty premiums ranging from $43-$58 per month, based on income. Nearly one in five families were disenrolled due to nonpayment over the next three months, and nearly half of surveyed disenrolled families reported inability to afford the premium as the reason for losing coverage. In Maryland, following the implementation of new premiums of $37 per family per month for families in its SCHIP program with incomes between 185%-200% of poverty, 28% of children subject to the new premium were disenrolled. Surveyed parents of disenrolled children cited a premium-related reason in nearly one of five cases, and state legislators subsequently eliminated the premiums.

**While some disenrollees obtained other coverage, many became uninsured.** Survey results in Oregon showed that over two thirds (67%) of poor adults who were disenrolled following the premium increases and tightened premium payment policies became uninsured. A survey of the slightly higher income disenrollees in Rhode Island showed that just over half (51%) became uninsured. In Utah, according to survey results, nearly two thirds (63%) of individuals disenrolled from the state's Primary Care Network Medicaid waiver program became uninsured.

*Impact of Cost Sharing on Access to Care*

**Cost sharing led to unmet medical need and financial stress, even when amounts were nominal or modest.** In Oregon, a survey of poor adults subject to increased cost-sharing under its Medicaid waiver showed that, among those with unmet needs, over a third (35%) could not get needed care due to cost, 24% reported that they did not have the copayment, and 17% reported that they did not get care because they owed the physician money (these options were not mutually exclusive). Focus group participants also had difficulty affording copayments and described instances in which they were unable to obtain prescription drugs because they could not pay. As one participant remarked, "Being able to afford $2 is a lot of money when you have absolutely nothing." Similarly, in Washington State, families, outreach workers, and providers noted that some immigrant families who became subject to new copayments under a state-funded coverage program had difficulty affording them, particularly for prescription drugs.

Analysis of utilization data in Utah had more mixed findings regarding the impact of new copayments in its Medicaid program, finding decreased utilization in some cases but not others, depending on the service examined and the analysis used. In a survey of adults subject to the new copayments, nearly three-quarters agreed that it feels good to "pay a little bit," but over four in ten agreed that copayments "seem small, but are actually a huge problem" and nearly 40% agreed they cause "serious financial difficulties."

*Impact of Increased Premiums and/or Cost Sharing on Providers and State Budgets*

**Coverage losses and affordability problems stemming from increased out-of-pocket costs led to increased pressures on providers and the health care safety-net.** Following its Medicaid coverage losses, Oregon saw an increase in emergency room use by uninsured patients and increased pressure on clinics. In addition, funds previously targeted to the uninsured were diverted by Portland area physicians to help Medicaid patients pay new prescription drug copayments. After Washington State attempted to transition a group of immigrant families from a state-funded Medicaid look-alike program to its state-funded Basic Health program, which charges premiums and cost sharing, it experienced a marked increase (54%) in use of its Alien Emergency Medicaid Program. This increase was the result of use by those who did not make the transition to Basic Health and those seeking services no longer covered by Basic Health. Providers also reported a substantial increase in demand for charity care, emergency room use and strains on clinic resources.

**Increases in beneficiary costs may have created savings for states, but they may accrue more from reduced coverage and utilization rather than increased revenue.** Only one study directly examined the impact of changes in premium and cost sharing policies on state program spending. However, the overall findings regarding the impact of premiums and cost sharing on enrollment and access suggest that states may be realizing savings stemming from reduced enrollment and utilization, rather than through increases in revenue. In fact, the available findings from Oregon showed that the state's premium revenues actually declined after it increased premium amounts and tightened payment policies because of the enrollment drop-off that occurred. As a result, Oregon reduced program spending due to lower enrollment, not higher premium collections. Further, because state program spending is matched by federal funding, the reduction in spending also resulted in a loss of federal match funds.

## Conclusion

Consistent with existing published research literature, these recent findings show that charging premiums and cost sharing can have a significant and immediate impact on low-income individuals' coverage and access to care. Low-income and poor families live on slim margins and often are not able to afford even nominal out-of-pocket costs. While some are able to get financial help to make payments, others are not as fortunate. While those at relatively higher incomes (e.g., 150% of poverty or $24,135 per year for a family of three in 2005) may have greater ability to afford costs, some still find increases in financial obligations difficult to shoulder. Importantly, loss of public coverage is often not replaced with private coverage; instead families become uninsured.

In sum, increasing financial obligations on low-income families may provide short-term state savings but these savings may accrue more from reduced coverage and utilization rather than increased revenue. Through premiums and cost sharing, individuals contribute to the cost of their coverage and care and these costs may help encourage more individual responsibility over health care choices and dissuade crowd out. However, further research is needed to determine at what level individuals can begin paying out-of-pocket costs and what amounts they can pay without experiencing negative consequences on their ability to obtain and maintain coverage and care.

## I. INTRODUCTION

Medicaid serves a diverse low-income population that is often poorer and sicker than the population covered by private insurance. It provides health insurance for 38 million low-income children and parents and acute and long-term care coverage for 12 million elderly and disabled individuals. (Low-income is less than 200% of the federal poverty level or $32,180 per year for a family of three in 2005.) SCHIP extends coverage to low-income children above Medicaid eligibility limits. The low-income individuals and families covered by Medicaid and SCHIP have very limited resources to devote to health care costs. Nationally, low-income families spend 7 out of every 10 dollars on basic living expenses, including housing, transportation, and food, leaving little income to cover other expenses, including health care.[1] Recognizing the significant health needs and limited financial resources of Medicaid and SCHIP beneficiaries, federal rules have limited the out-of-pocket costs states can charge beneficiaries (see text box).

**Federal Medicaid and SCHIP Premium and Cost Sharing Rules**

Premiums are regular amounts that a family or individual must pay, generally on a monthly basis, to enroll in and maintain health insurance coverage. Cost sharing takes a number forms, but is an out-of-pocket payment an individual is required to pay for a covered service. Cost sharing generally occurs in three forms: (1) deductibles are specified dollar amounts that must be incurred before coverage will begin to pay for services, (2) copayments are fixed amounts that must be paid when a service is received, (3) coinsurance is a fixed percentage of costs (e.g., 10%) that must be paid for a covered service.

**Medicaid Rules.** States cannot charge most Medicaid beneficiaries premiums or enrollment fees. Children, pregnant women, and elderly and disabled beneficiaries who receive SSI cash assistance cannot be charged cost sharing. "Nominal" cost sharing is permitted for other groups, such as parents, but cost sharing cannot be imposed on any beneficiaries for emergency room visits, family planning services and hospice care. Under regulations, a nominal deductible is $2 per month per family; a nominal copayment may range from $0.50 to $3.00, depending on the amount of the state's payment for the item or service; and a nominal coinsurance requirement is 5% of the state's payment rate for the item or service. There is one exception to these limitations; states can charge somewhat higher amounts for non-emergency use of an emergency room.

**SCHIP Rules.** Under SCHIP, the amount of cost sharing permitted depends on the type of SCHIP program and the child's family income. In SCHIP programs that are Medicaid expansions, the Medicaid rules apply, i.e., children cannot be charged cost sharing. In separate SCHIP programs, states can charge children with incomes at or above 150% of the federal poverty level (FPL), premiums, enrollment fees, and other cost sharing that, in the aggregate, do not exceed five percent of family income. The five percent limit also applies to children with income below 150% FPL, but above Medicaid eligibility levels, and, in addition, states must limit out-of-pocket charges for these children to nominal amounts.

In both Medicaid and SCHIP, providers cannot "balance bill" or charge individuals beyond the limited cost sharing amounts. Further, providers generally cannot deny services to a beneficiary based on inability to pay cost sharing, although the beneficiary remains liable for the cost sharing amount.

Even when insured, low-income individuals already devote a substantial share of their incomes to health care costs because they pay a significant portion of their health care expenses (not including premiums) out-of-pocket. Recent analysis of Medical Expenditure Panel Survey data found insured low-income individuals devote about 17% of their incomes to health care,

[1] Claudia Williams, James Rosen, Julie Hudman, and Molly O'Malley, "Challenges and Tradeoffs in Low-Income Family Budgets: Implications for Health Coverage," Kaiser Commission on Medicaid and the Uninsured, April 2004.

compared to 6% for higher income individuals.[2] The average low-income privately insured individual pays 35% of his or her health care expenses out-of-pocket, and, while Medicaid appears to offer some cost protection, adult Medicaid beneficiaries still pay about 12% of their health care expenses out-of-pocket.[3]

Over the years, as some states expanded Medicaid to somewhat higher income groups, they obtained waivers of federal law to impose premiums and copayments on these new coverage groups. Premiums and cost sharing were intended to better align Medicaid coverage for people at these relatively higher incomes with private coverage to address equity issues and to prevent "crowd out" of private coverage (i.e., people dropping private coverage for public coverage). Some policymakers also view premiums and cost sharing as mechanisms to encourage more individual responsibility over health care choices. Premiums and cost sharing can also serve as ways to limit or reduce state program costs to address budget shortfalls.

In recent years, a number of states have increased beneficiary costs through options available under current law or through waivers that allow them to make changes not otherwise allowed under federal law. Under waivers, states have increased costs above allowable amounts, imposed costs on groups who are exempt under current law, and/or created tiered programs, in which different groups of beneficiaries have different benefits and cost sharing.

The use of premiums and cost sharing for the low-income population needs to be carefully assessed. Research has found that premiums can limit participation in publicly-funded coverage and that many families who participate in public coverage either cannot afford or do not pay premiums and enrollment fees on time, even when these amounts are relatively low.[4] It also showed that cost sharing has a greater impact on low-income populations, that it can reduce use of essential services, and that poorer health outcomes are associated with higher cost sharing for the low-income population.[5]

In light of increasing discussion of applying cost sharing and premiums to the low-income population, this brief reviews recent changes in states' premium and cost sharing policies in their Medicaid, SCHIP, and other public coverage programs and summarizes available evidence on the impact of these changes. We identified 13 relevant studies conducted in seven states between 2001 and 2005 by contacting all 50 states and the District of Columbia via telephone and performing an internet search of research institutions, government websites and foundations (see Appendix A for a table summarizing the studies). These studies employed a range of

[2] Kaiser Family Foundation analysis of Medical Expenditure Panel Survey pooled data from 1999-2002. Analysis is for low-income adult individuals with insurance for the full year. Low-income is less than 200% of the federal poverty level or $32,180 per year for a family of three in 2005. Income of zero or less is recoded as $1. To reduce the potential influence of outliers, the ratio of out-of-pocket spending to family income is limited to 1.
[3] Kaiser Family Foundation analysis of Medical Expenditure Panel Survey pooled data from 1999-2002. Analysis is for low-income adult individuals. Medicaid beneficiaries are identified as having Medicaid for the full year and no private insurance during that time; privately insured individuals are identified as having private insurance for the full year and no Medicaid during that time.
[4] Hudman, Julie and Molly O'Malley, "Health Insurance Premiums and Cost-sharing: Findings from the Research on Low-Income Populations, Kaiser Commission on Medicaid and the Uninsured, March 2003 and Ku, L, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities, May 2003.
[5] Ibid.

approaches, including examining enrollment trends using state administrative data, surveys of disenrollees to probe reasons for loss of public coverage, and focus groups with affected individuals and providers who serve the low-income population.

The key findings from these studies are summarized below, beginning with findings on the impact of premiums on enrollment, followed by findings on the impact of cost sharing on access to care, and concluding with findings on the impact of increased out-of-pocket costs on providers. The brief concludes by discussing the implications of these findings.

## II. IMPACT OF PREMIUMS ON ENROLLMENT

Premiums are regular amounts that a family or individual must pay, generally on a monthly basis, to enroll in and maintain health insurance coverage. States cannot charge most Medicaid beneficiaries premiums or enrollment fees. In separate SCHIP programs, states can charge children with incomes at or above 150% of poverty premiums and enrollment fees so long as, in the aggregate, these costs as well as other cost sharing, do not exceed five percent of family income.

Over the past several years, some states have made a number of changes in their premium policies including increasing the level of premiums, expanding the groups of beneficiaries subject to premiums, and/or implementing new penalties for nonpayment of premiums, such as lock-out periods. For example, between April 2003 and July 2004, 16 states implemented new or increased existing premiums or targeted them to families at lower income levels in their Medicaid or SCHIP programs.[6] Most of these changes occurred in states' SCHIP programs, since states have limited ability to charge premiums in Medicaid except under waivers. Under Medicaid waivers, some states have begun charging premiums at lower incomes than previously seen, including those with no income.

As states have implemented new premium policies in recent years, states and other organizations have undertaken studies to evaluate the impact of the policy changes. The following are key findings from recent studies examining the impact of changes in premium policies on enrollment in Medicaid, SCHIP, and other public coverage programs in seven states. The studies in Oregon, Washington, Utah, and Vermont, examine premium policy changes that impacted groups at very low incomes, including, in some cases, those with no incomes. The findings from Rhode Island, Wisconsin, and Maryland provide insight into the impact of increased premiums on individuals and families at the upper end of the low-income spectrum (i.e., above 150% of poverty or $24,135 per year for a family of three in 2005).

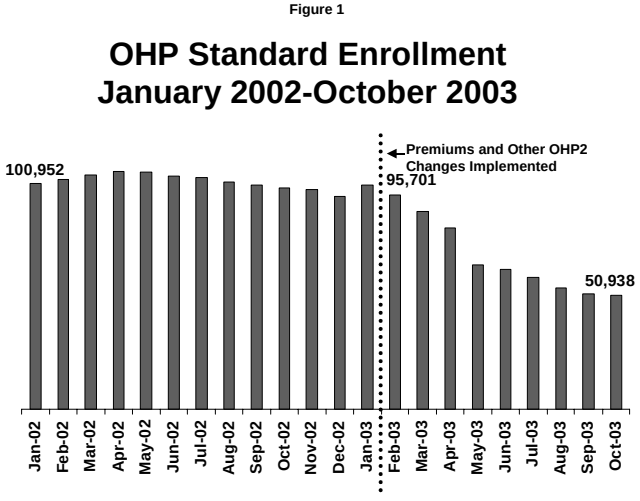
[6] Cohen Ross, D. and L. Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, October 2004.

***Oregon: Medicaid Waiver Coverage***

Policy Change: In 2003, Oregon implemented a number of program changes, including increased premiums ranging from $6-$20 per person based on income and stricter premium payment policies for parents and other adults with incomes below 100% of poverty in its OHP Standard Medicaid waiver program. Premiums are charged for all OHP Standard enrollees, including those with no incomes. Premiums increased for some individuals (e.g., from $6 to $9 for those with incomes between 10%-50% of poverty) and changed from a per couple to a per person basis (e.g., from $18 per couple to $15 per person for those with incomes between 50%-65% of poverty). Under the stricter payment process, the state disenrolls people after missing one payment and locks them out of coverage for six months and individuals can no longer have premiums waived for extenuating circumstances, such as homelessness. Currently, enrollment is closed, so individuals cannot reenroll.

Impact: Following the premium changes, enrollment in the OHP Standard program dropped by almost half, or 50,000 people (Figure 1).[7] Most of the change was the result of disenrollments, although researchers also observed considerable declines in new enrollments. There were significant enrollment drops among all those subject to premiums, but the lowest income people experienced the greatest losses.

Figure 1




Source: McConnell, J. and N. Wallace, "Impact of Premium Changes in the Oregon Health Plan," Office for Oregon Health Policy and Research, February 2004.

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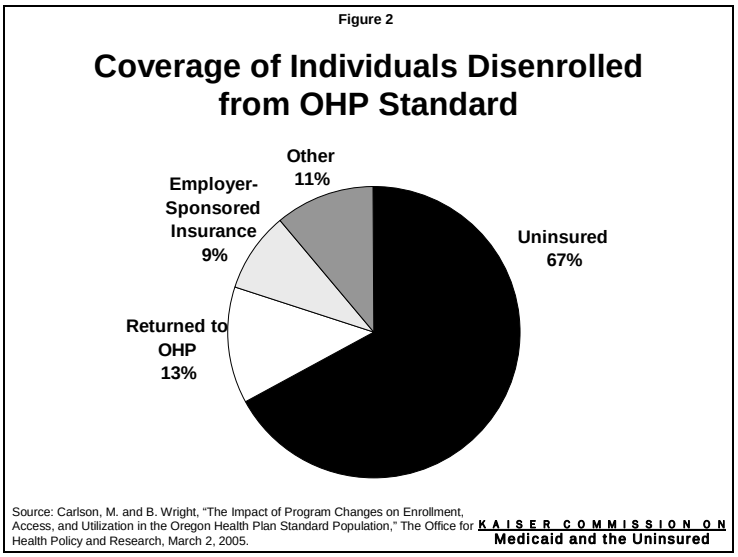
Nearly a third (31%) of surveyed disenrollees reported premium costs as a primary reason they lost coverage.[8] In focus groups, individuals who lost OHP Standard coverage cited both problems affording the premium as well as problems adhering to the strict payment policy as

[7] McConnell, J. and N. Wallace, "Impact of Premium Changes in the Oregon Health Plan," The Office for Oregon Health Policy and Research, February 2004.

[8] Carlson, M. and B. Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population," The Office for Health Policy and Research, March 2, 2005.

primary factors leading to their coverage loss.[9] Survey results also found that two-thirds of those who lost OHP Standard coverage became uninsured (Figure 2).[10]

Figure 2




In 2002, before the waiver changes, the potential monthly revenue from premiums averaged about $800,000 (or about $9.6 million annually).[11] In February 2003, potential monthly premium revenues increased to $900,000 reflecting the premium amount increases.[12] However, in the following months, the decline in enrollment led to a net decrease in revenues. By late 2003, the potential monthly premium revenue averaged about $500,000 (about $6 million annually), approximately 63% of the revenue levels seen in 2002.[13] Thus, it appears the state collected more revenues through premiums prior to the premium increase and stricter payment policies.

[9] LeCouteur, G., Perry, M., Artiga, S., and D. Rousseau, "The Impact of Medicaid Reductions in Oregon: Focus Group Insights," Kaiser Commission on Medicaid and the Uninsured, December 2004.
[10] McConnell, J. and N. Wallace
[11] Ibid.
[12] Ibid.
[13] Ibid.

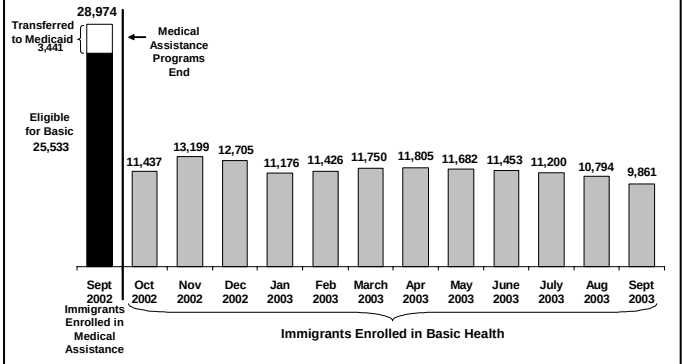
### *Washington: State Funded Coverage for Recent Immigrants*

Policy Change: In 2002, Washington eliminated a state-funded Medicaid look-alike program for low-income immigrant families who were not eligible for federally-matched Medicaid coverage. These families became eligible for the state-funded Basic Health program which is designed for low-income workers in the state who are not eligible for Medicaid. Basic Health has more limited benefits and premiums and cost sharing that were not charged in the Medicaid look-alike program.

Impact: Less than half (48%) of the immigrant families successfully enrolled in Basic Health (Figure 3).[14] The majority (61%) of families who successfully made the initial transition relied on sponsorship from clinics or community organizations or other donated assistance to pay premiums (Figure 4).[15] The limited enrollment of immigrant families in Basic Health stemmed from a number of factors, but premiums appeared to be a significant factor. In interviews, outreach workers noted that the premiums were too expensive for many families, and, in focus groups, families also communicated affordability concerns.[16] Interviews with families revealed that some were attempting to enroll children but not eligible adults because of the premium costs.[17] One parent expressed, "My priorities were getting medical coverage. I thought of cutting some other expenses…even if my wife and I had to give up medical coverage for ourselves."[18] Premiums also impacted families' ability to maintain Basic Health coverage. Over a third (36%) of those who were disenrolled within a year after the initial transition were disenrolled due to unpaid premiums.[19]

Figure 3

**Transition of Immigrant Children and Parents from Medical Assistance to Basic Health**




Source: Gardner, M. and J. Varon, "Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations," Kaiser Commission on Medicaid and the Uninsured, May 2004.

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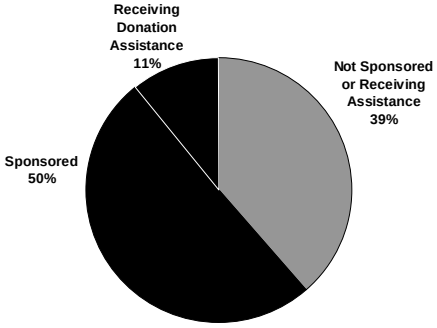
Figure 4

**Sponsorship and Premium Donation Assistance Among Basic Health Transition Group Enrollees**




Source: Gardner, M. and J. Varon, "Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations," Kaiser Commission on Medicaid and the Uninsured, May 2004.

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[14] Gardner, M. and J. Varon, "Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations," Kaiser Commission on Medicaid and the Uninsured, May 2004.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Ibid.

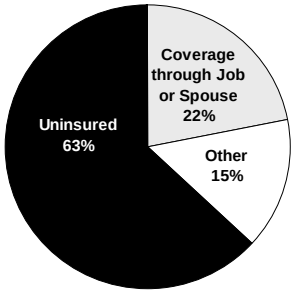
***Utah: Medicaid Waiver Coverage***

Policy Change: In July 2002, Utah implemented a Medicaid waiver that expanded coverage of primary care services, called the Primary Care Network (PCN), to adults with incomes below 150% of poverty who were not previously eligible for Medicaid. To enroll, most eligible adults had to pay a $50 annual enrollment fee. In July 2003, the state legislature reduced the fee to $15 for eligible adults receiving general assistance welfare payments, and, in July 2004, the legislature reduced the fee to $25 for all other eligible adults with incomes below 50% of poverty.

Impact: Over a quarter (27%) of PCN enrollees were disenrolled during July through September 2003, when many enrollees were required to repay the annual fee to retain coverage.[20] A survey of disenrollees found that 29% indicated financial barriers to their reenrollment, and nearly two-thirds (63%) of disenrollees reported being uninsured (Figure 5).[21]

Figure 5

**Coverage of Individuals Disenrolled from Primary Care Network**




Source: Utah Primary Care Network Disenrollment Report, August 2004.

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[20] Office of Health Care Statistics, "Utah Primary Care Network Disenrollment Report, July-August 2003," Utah Department of Health, August 2004.
[21] Ibid.

### *Vermont: Medicaid Waiver and SCHIP Coverage*

Policy Change: In January 2004, Vermont increased sliding-scale premiums from $20-$50 every three months to $25-$70 per month for families with incomes between 185%-300% of poverty in its SCHIP program, Dr. Dynasaur. It also increased premiums from $10-$50 every six months to $10-$65 per month for adults with incomes between 50%-185% of poverty in its Vermont Health Access Plan (VHAP) Medicaid waiver program. Additionally, the state implemented new premiums ranging from $13-$25 per month for adults with incomes between 150-225% of poverty in its VHAP-Pharmacy and VScript waiver programs, which help cover the cost of drugs for residents who lack prescription coverage.[22]

Impact: A total of over 40,000 people were billed increased premiums in December 2003. In January 2004, about 4,500 or 11% were disenrolled for nonpayment of premiums, and over 3,000 were still disenrolled as of February 2004 (Figure 6).[23] Disenrollment rates were highest for VHAP enrollees. It appears a number of people reenrolled in February 2004, particularly among Dr. Dynasaur enrollees, reflecting the fact that individuals are not locked out from coverage after they are disenrolled. In a survey of disenrollees, over a quarter (28%) of Dr. Dynasaur respondents reported that they disenrolled because of cost and nearly a third reported that they disenrolled (30%) because they were confused or dissatisfied (Figure 7). Cost was an even more significant disenrollment factor, for VHAP respondents (69%) and VHAP-Pharmacy/V-Script respondents (42%).

Figure 6

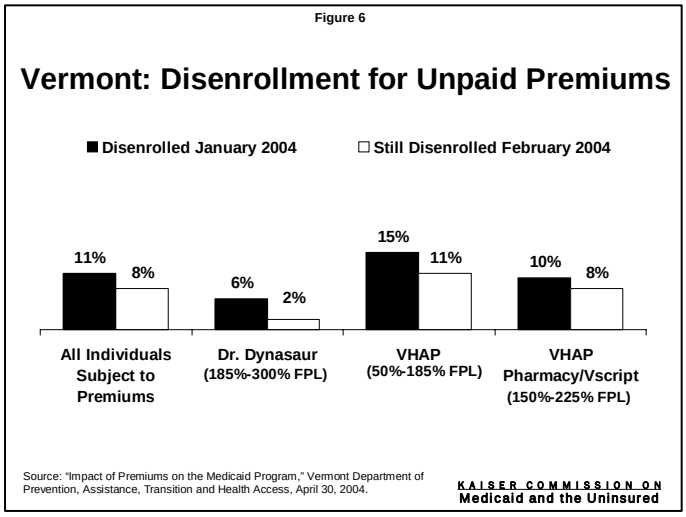
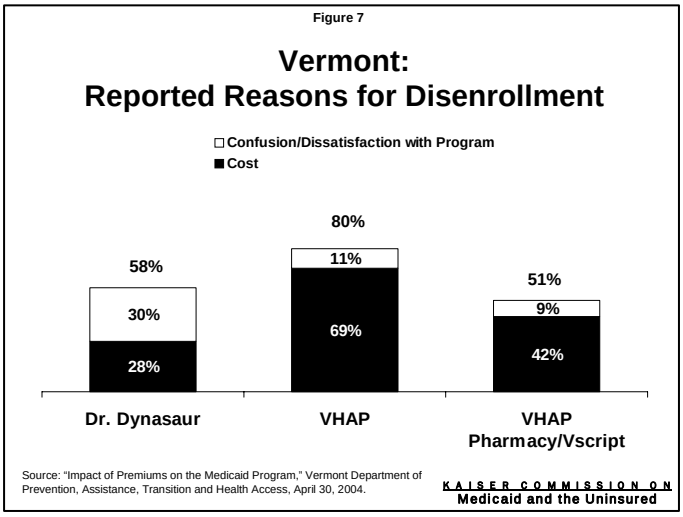



Figure 7




[22] At the same time premiums increased, the state eliminated all copayments and coinsurance in VHAP, except for emergency room visits, and eliminated all copayments, coinsurance, and deductibles in its VHAP-Pharmacy and V-Script programs.

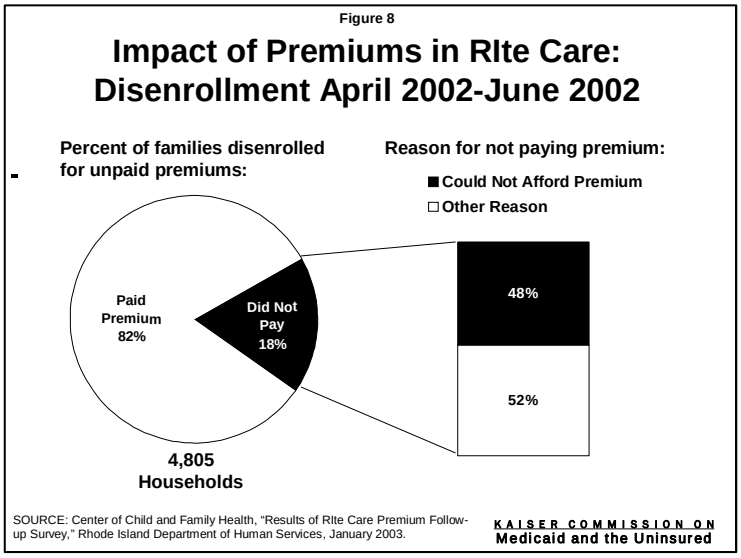
[23] Department of Prevention Assistance, Transition and Health Access, "Impact of Premiums on the Medicaid Program," April 2004.

***Rhode Island: Medicaid Waiver Coverage***

Policy Change: In January 2002, the Rhode Island Medicaid waiver program, RIte Care, began charging families with incomes above 150% of poverty premiums ranging between $43-$58 per month.

Impact: In the first three months that the premium policy was enforced, about 18% of families subject to premiums were disenrolled due to nonpayment (Figure 8).[24] A survey of families who were disenrolled due to nonpayment found that the most commonly reported reason for losing coverage was inability to afford the premium (48%).[25] Just over half (51%) of disenrollees became uninsured, over a third (35%) enrolled in employer-sponsored insurance, and 14% re-enrolled in RIte Care because their income fell below 150% of poverty and, as such, they were no longer subject to premiums.[26]

Figure 8




[24] Center of Child and Family Health, "Results of RIte Care Premium Follow-up Survey," Rhode Island Department of Human Services, January 2003.
[25] Ibid.
[26] Ibid.

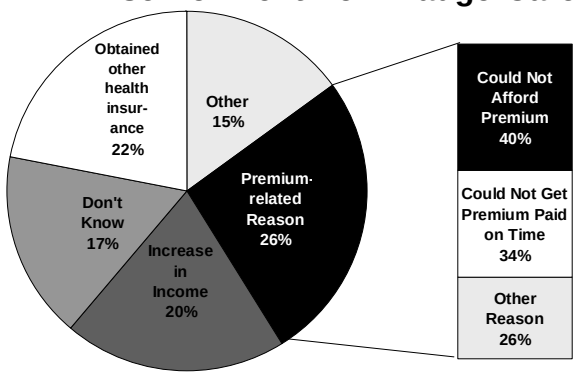
***Wisconsin: Medicaid Waiver Coverage***

Policy Change: In 1999, Wisconsin implemented its BadgerCare Medicaid waiver program, which coverage parents and children in families with incomes up to 185%. BadgerCare charges premiums for families with incomes above 150% of poverty, who account for about 9% of enrollees. Recently, the state analyzed enrollment data and conducted a survey to gain insight into the impact of premiums on "churning"—repeated movement into and out of the program—and enrollment decisions.

Impact: The state's analysis found that premium-paying families were less likely to remain enrolled over time, but the difference from families not subject to premiums was small.[27] Further, the state noted that the difference could be due to premium-paying families' greater likelihood of having income increases that make them ineligible for the program, rather than premiums.[28] Analysis of reenrollment patterns suggests that premiums delay reenrollment of families.[29] This is consistent with the fact that families who are disenrolled due to nonpayment of premiums must wait 6 months prior to reenrolling. Premiums also appeared to contribute to disenrollment from BadgerCare.[30] In a survey of disenrolled families who were subject to premiums, the most frequently cited reason for disenrollment was a "premium-related reason" (26%) (Figure 9).[31] Among those who lost BadgerCare coverage because of problems paying premiums, 40% said they could not afford the premium and over a third said they could not get the premium paid on time.

Figure 9

**Families' Self-Reported Reasons for Disenrollment from BadgerCare**




Source: West, N., RTI International, "The Impact of Premiums on Wisconsin's BadgerCare Program," Presentation at Academy Health Annual Research Meeting, June 2004.

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[27] Gavin, N.I., N.D. West, and N.F. Lenfestey, "Evaluation of the BadgerCare Medicaid Demonstration" RTI International, December 2003.
[28] Ibid.
[29] Ibid.
[30] This analysis also examined the impact of premiums on enrollment among eligible but unenrolled families. However, nearly half of families included in that analysis reported that they did not enroll because they found out they did not qualify. The proportion of families reporting premiums as an enrollment barrier is not presented here because it understates the impact of premiums on "eligible" families, since nearly half of respondents were not, in fact, eligible.
[31] Gavin, N.

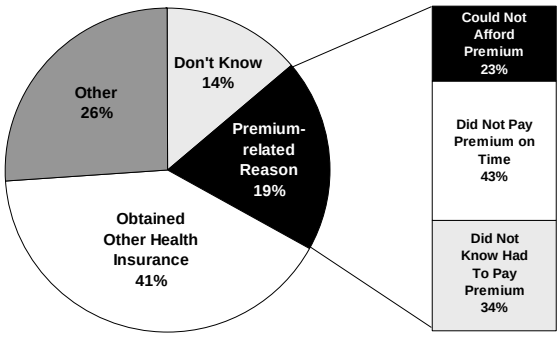
***Maryland: SCHIP Coverage***

Policy Change: In July 2003, Maryland began charging premiums for about 6,400 children with incomes between 185-200% of poverty in its SCHIP program.

Impact: In the first few months following the new premium requirement, approximately 1,800 children, 28% of those subject to the premium, were disenrolled.[32] The state surveyed parents of disenrolled children to determine the impact of the new premium. The majority of respondents indicated that the reason for their child's disenrollment was that they obtained other insurance (41%). Nearly one in five cited a premium-related reason, including not being able to afford the premium, not paying the premium on time, and not knowing that they had to pay the new premium (Figure 10).[33] The state legislature later eliminated the premiums.

Figure 10

**Families' Self-Reported Reasons for Disenrollment from Maryland SCHIP Program**




Source: Maryland Department of Health and Mental Hygiene, "Maryland Children's Health Program, Assessment of the Impact of Premiums," April 2004.

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[32] Maryland Department of Health and Mental Hygiene, Maryland Children's Health Program, "Assessment of the Impact of Premiums," April 2004.
[33] Ibid

## III. IMPACT OF COST SHARING ON ACCESS TO CARE

Cost sharing is an out-of-pocket payment an individual is required to pay for a covered service. Many Medicaid beneficiaries, including children, pregnant women, and elderly and disabled beneficiaries who receive SSI cannot be charged cost sharing. "Nominal" cost sharing is permitted for other groups, such as parents, but cannot be imposed on certain services such as emergency room visits. Under regulations, a nominal deductible is $2 per month per family, a nominal copayment may range from $0.50-$3.00, and a nominal coinsurance requirement is 5% of the state's payment rate for the item or service.

States have somewhat greater flexibility to charge cost sharing in separate SCHIP programs. States can charge children with incomes at or above 150% of poverty cost sharing that, combined in the aggregate with premiums or enrollment fees, does not exceed five percent of income. The five percent limit also applies to children with income below 150% of poverty but above Medicaid eligibility levels, and, in addition, states must limit charges for these children to nominal amounts.

Over the past several years, a number of states have increased cost sharing obligations or imposed them on new populations. Some have done so under the options available under current law, while others have used waiver flexibility to charge higher amounts or to impose them on populations or services that are excluded under current law. A total of 20 states imposed new or higher co-payments in Medicaid in fiscal year 2004, and 9 states imposed new or higher copayments in fiscal year 2005.[34]

Given the changes in cost sharing policies in recent years, a number of recent studies have examined the impact of cost sharing on beneficiaries' ability to access necessary care in Medicaid, SCHIP, and other public coverage programs. The following are key findings from several recent studies.

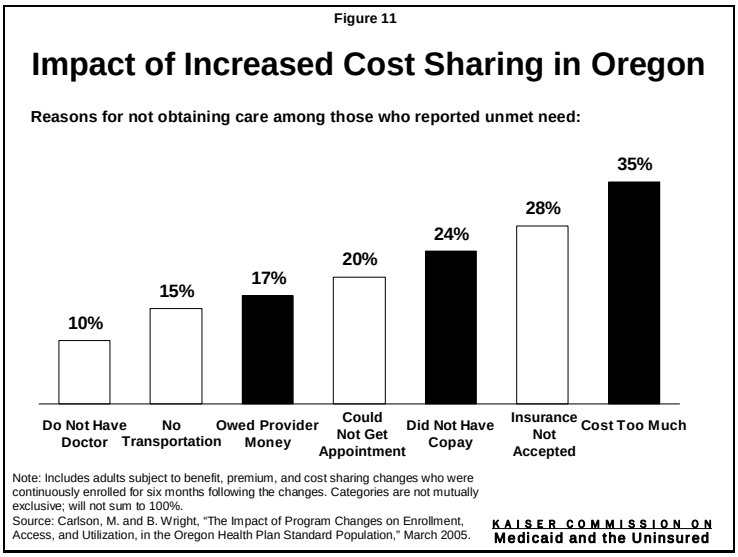
[34] Smith, V, et al., *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005: Results from a 50-State Survey*, Health Management Associates for the Kaiser Commission on Medicaid the Uninsured, October 2004.

### *Oregon: Medicaid Waiver Coverage*

Policy Change: At the same time Oregon increased its premiums in its OHP Standard Medicaid waiver program, which covers poor parents and other adults, it began charging new cost sharing above the nominal amounts allowed under current Medicaid law. Copayments ranged from $3 to $250 based on service. (These copayments were later eliminated in June 2004, following a court order.)

Impact: Physicians described instances of people avoiding seeking needed care because of costs and cases of patients not taking or cutting back on prescribed medications because they could not afford to fill them.[35] A survey of adults subject to increased cost sharing who reported unmet need found that over a third (35%) reported they could not obtain needed care due to cost, 24% reported they did not have the copayment, and 17% reported that they did not get care because they owed the physician money (these factors were not mutually exclusive) (Figure 11).[36] In focus groups, individuals described significant challenges involved with paying even nominal copayments. As one woman remarked, "Being able to afford $2 is a lot of money when you have absolutely nothing."[37] Some said they relied on help from family, friends, charities, or churches to pay for copayments.[38] In particular, several reported difficulty affording copayments for prescription drugs and described instances in which they had been unable to obtain their drugs because they could not pay.[39] Others said they had to do without food or some other necessity to pay for their medications.[40]

Figure 11




[35] Hines, P., et al, "Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impacts in Multnomah and Washington Counties," The Office for Oregon Health Policy and Research, December 2003.
[36] Carlson, M. and B. Wright.
[37] LeCouteur, G., op cit.
[38] Ibid.
[39] Ibid.
[40] Ibid.

***Utah: Adult Medicaid Coverage and "Non-Traditional Medicaid" Waiver Coverage***

Policy Change: Under its recent waiver, Utah imposed new copayments on previously eligible parents in its Medicaid waiver program, which it calls "Non-Traditional Medicaid." Soon after, the state legislature also approved nominal copayments for other previously eligible adults in its Medicaid program, excluding pregnant women.

Impact: Early analysis of the impact of the new copayments has somewhat mixed findings. The state undertook a comprehensive analysis that included analysis of utilization data, focus groups, and a survey. When it compared actual utilization of services with modeled expectations, it found that the copayments did not have a statistically significant impact on utilization in most cases, although there were statistically significant decreases in utilization for some services, such as prescription drugs.[41] In the state's accompanying survey, nearly three-quarters (72%) of respondents agreed that it feels good to pay a little bit, but over a four in ten (42%) agreed that copayments "seem small, but are actually a huge problem" and nearly 40% agreed that they cause "serious financial difficulties."[42] Reanalysis of the state's utilization data, conducted by the Center on Budget and Policy Priorities (CBPP) using different methods and assumptions for modeling projected utilization, consistently found that the copayments led to decreased utilization of services, including hospital admissions, physician visits, prescription drugs, and outpatient hospital clinic visits.[43]

***Washington: State-Funded Coverage for Recent Immigrants***

Policy Change: In 2002, Washington eliminated a state-funded Medicaid look-alike program for recent immigrant families. These families became eligible for the state-funded Basic Health program with more limited benefits and premiums and cost sharing that were not charged in the Medicaid look-alike program.

Impact: Families, outreach workers, and providers noted that some families who enrolled in Basic Health had difficulty affording copayments, particularly for prescription drugs.[44] According to a health plan administrator, "Patients who need drugs that are new on the market find themselves in quite a predicament. These are the more expensive drugs that have no generic equivalent—for example, anti-rejection transplant medications. Basic Health requires the enrollee to pay 50 percent of the cost. Many Basic Health enrollees cannot afford to pay these high monthly copays."[45]

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[41] Office of the Executive Director, Utah Department of Health, "Medicaid Benefits Change Impact Study," 2003 Utah Public Health Outcome Measures Report, December 2003.
[42] Ibid.
[43] The state used econometric models to examine trends in health care use with and without the copayments. The state baselines estimated that, without any copayments or other policy changes, utilization of physician and inpatient hospital services would decline significantly. In contrast, the CBPP analysis assumes that utilization would have either continued to rise or flatten out if copayments had not been imposed. Ku, L., Deschamps, E., and J. Hilman, "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program," Center on Budget and Policy Priorities, November 2004.
[44] Gardner, M. and J. Varon.
[45] Ibid.

## IV. IMPACT OF OUT-OF-POCKET COSTS ON PROVIDERS

As noted, under current law, providers cannot deny services to a Medicaid or SCHIP beneficiary based on inability to pay cost sharing. The beneficiary remains liable for the cost sharing amount, but, if the provider cannot or does not collect the amount, it becomes a cost borne by the provider. Recognizing that premiums can lead to coverage losses and cost sharing can be unaffordable for some beneficiaries, some recent studies have examined the impact of increasing out-of-pocket costs on providers and on the health care safety net.

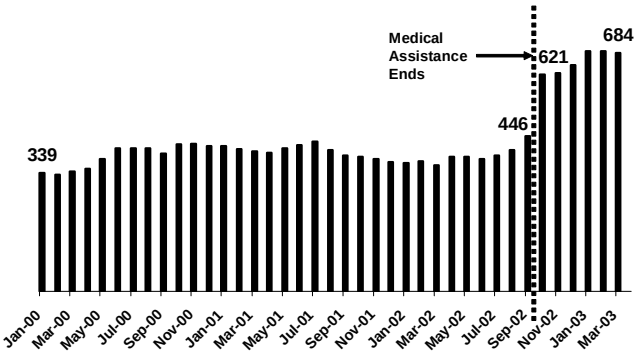
### *Washington: State-Funded Coverage for Recent Immigrants*

Policy Change: In 2002, Washington eliminated a state-funded Medicaid look-alike program for recent immigrant families. These families became eligible for the state-funded Basic Health program with more limited benefits and premiums and cost sharing that were not charged in the Medicaid look-alike program.

Impact: Following the elimination of the state-funded Medicaid look-alike program, Washington experienced a marked increase (54%) in use of its Alien Emergency Medicaid Program, which serves individuals who have an emergency medical condition but who are not eligible for Medicaid because of their immigration status (Figure 12).[46] This increase was the result of use by those who did not make the transition to Basic Health and those seeking services no longer covered by the more limited benefits of Basic Health.[47] Many providers also saw a substantial increase in demand for charity care or an increase in emergency room usage.[48] One pediatric hospital estimated that it spent about $100,000 per month on services used by immigrants who had become uninsured or who used services not covered by Basic Health.[49] Clinic workers also reported that they were facing increasing strains on their resources.[50]

Figure 12

**Children Receiving Alien Emergency Medical Before and After Elimination of Medical Assistance**




Source: Washington State Medical Assistance Administration

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[46] Ibid.
[47] Ibid.
[48] Ibid.
[49] Ibid.
[50] Ibid.

***Oregon: Medicaid Waiver Coverage***

Policy Change: In 2002, Oregon increased premiums, implemented stricter premium payment policies, and increased cost sharing for poor parents and other adults in its OHP Standard Medicaid waiver program.

Impact: As noted, Oregon experienced substantial enrollment declines in its Medicaid program following implementation of increased premiums and stricter premium payment policies. Additionally, many of those who remained enrolled reported problems accessing care due to difficulties affording increased copayments. Preliminary analysis, based on the first three months following the program changes, found that visits to an emergency room by uninsured patients increased by 17%.[51] Additionally, survey results found increased emergency department use among those who lost Medicaid coverage, particularly among the lowest income individuals and individuals with chronic conditions.[52]

A study examining the impact of the changes on health centers found that administrators and physicians reported diverting considerable clinic resources to finding resources for patients who lost their Medicaid coverage and that copayments were causing an increased number of "no shows," which also wastes resources and can contribute to provider revenue shortfalls.[53] Finally, limited resources intended to help the uninsured were stretched to meet the new gaps in coverage. For example, when Portland area physicians saw that many of their Medicaid patients were not filling their prescriptions due to copayments, they diverted some of the funds for the uninsured to help these patients.[54]

## V. CONCLUSION

Consistent with existing published research literature, these recent findings show that charging premiums and cost sharing can have a significant and immediate impact on low-income individuals' coverage and access to care and can also have implications for providers:

- **New or increased premiums served as a barrier to obtaining and/or maintaining public coverage.** Studies in a number of the states found that premiums contributed to disenrollment, particularly among the lowest income individuals. For example, Oregon experienced steep enrollment declines largely due to its increased premiums and tightened premium payment policies. Similarly, Vermont experienced enrollment declines in its Medicaid and SCHIP programs after increasing premiums. Overall, the findings suggest that both premium amounts and premium payment methods and policies can impact individuals' ability to make premium payments and maintain coverage.

[51] Lowe, R.A., et al, "Changes in Access to Primary Care for Oregon Health Plan Beneficiaries and the Uninsured: A Preliminary Report Based on Oregon Health and Science University Emergency Department Data," The Office for Oregon Health Policy and Research, September 2003.
[52] Carlson, M. and B. Wright
[53] Hines, P., et al.
[54] Ibid.

- **Premiums disproportionately impacted those with the lowest incomes, but also led to disenrollment among those with incomes above 150% of poverty.** In states such as Rhode Island and Maryland, which limited premiums to those at relatively higher incomes, premiums did not appear to have as significant effect on enrollment as in states that imposed premiums at lower income levels. However, premiums did lead to disenrollment among some families in this relatively higher income range.

- **While some disenrollees obtained other coverage, many became uninsured.** Survey results in several of the states found that a substantial portion of disenrollees reported being uninsured after losing their public coverage. For example, over two-thirds of adults disenrolled following the premium changes in Oregon reported being uninsured. A survey of slightly higher income disenrollees in Rhode Island showed that just over half became uninsured. Finally, survey results in Utah found that nearly two-thirds of individuals disenrolled from its Primary Care Network program became uninsured.

- **Cost sharing led to unmet medical need and financial stress, even when amounts were nominal or modest.** Data from a range of sources in several states found that cost sharing was impeding individuals' ability to access needed care and causing financial difficulties. Survey and focus group respondents in Oregon noted that they were not obtaining needed services, including prescription drugs, due to cost. Similarly, families, outreach workers, and providers in Washington State noted that some immigrant families who became subject to new copayments had difficulty affording them, particularly for prescription drugs. Analysis of utilization data in Utah had more mixed findings, finding decreased utilization following copayment increases in some cases but not others, depending on the service examined and the analysis used. Further, the state's survey results found that while most respondents said it "felt good to pay a little bit," many also described copayments as a "huge problem" and said they cause "serious financial difficulties."

- **Coverage losses and affordability problems stemming from increased out-of-pocket costs led to increased pressures on providers and the health care safety-net.** Following its Medicaid coverage losses, Oregon saw an increase in emergency room use by uninsured patients and increased pressure on clinics. In addition, funds previously targeted to the uninsured were diverted by Portland area physicians to help Medicaid patients pay new prescription drug copayments. Washington State experienced a marked increase in use of its Alien Emergency Medicaid Program stemming from coverage losses and access problems that occurred after it attempted to transition a group of immigrant families from its Medicaid look-alike program to its state-funded Basic Health program, which has more limited benefits and charges premiums and cost sharing. Providers also reported a substantial increase in demand for charity care, emergency room use and strains on clinic resources.

- **Increases in beneficiary costs may have created savings for states, but they may accrue more from reduced coverage and utilization rather than increased revenue.** Only one study directly examined the impact of changes in premium and cost sharing policies on state program spending. However, the overall findings regarding the impact of premiums and cost sharing on enrollment and access suggest that states may be realizing savings stemming from reduced enrollment and utilization, rather than through increases in revenue. In fact, the

available findings from Oregon showed that the state's premium revenues actually declined after it increased premium amounts and tightened payment policies because of the enrollment drop-off that occurred. As a result, Oregon reduced program spending due to lower enrollment, not higher premium collections. Further, because state program spending is matched by federal funding, the reduction in spending also resulted in a loss of federal match funds.

Taken together, these findings illustrate the point that low-income and poor families live on slim margins and often are not able to afford even nominal out-of-pocket costs. While some are able to get financial help to make payments, others are not as fortunate. Those at relatively higher incomes (e.g., 150% of poverty or $24,135 per year for a family of three in 2005) may have somewhat greater ability to afford costs, but some still find increases in financial obligations difficult to shoulder. Importantly, these findings show that loss of public coverage is often not replaced with private coverage; instead families become uninsured.

In sum, increasing financial obligations on low-income families may provide short-term state savings but these savings may accrue more from reduced coverage and utilization rather than increased revenue. Through premiums and cost sharing, individuals contribute to the cost of their coverage and care and these costs may help encourage more individual responsibility over health care choices and dissuade crowd out. However, further research is needed to determine at what level individuals can begin paying out-of-pocket costs and what amounts they can pay without experiencing negative consequences on their ability to obtain and maintain coverage and care.

Prepared by Samantha Artiga and Molly O'Malley of the Kaiser Commission on Medicaid and the Uninsured. The authors thank Catherine Barnard for her assistance in gathering research for this brief and Barbara Lyons and Diane Rowland for their comments and guidance.

REFERENCES

Carlson, M. and B. Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population," The Office for Health Policy and Research, March 2, 2005.

Center of Child and Family Health, "Results of RIte Care Premium Follow-up Survey," Rhode Island Department of Human Services, January 2003.

Claudia Williams, James Rosen, Julie Hudman, and Molly O'Malley, "Challenges and Tradeoffs in Low-Income Family Budgets: Implications for Health Coverage," Kaiser Commission on Medicaid and the Uninsured, April 2004.

Donna Cohen Ross and Laura Cox, "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families," Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, October 2004.

Gardner, M. and J. Varon, "Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations," Kaiser Commission on Medicaid and the Uninsured, May 2004.

Gavin, N.I., N.D. West, and N.F. Lenfestey, "Evaluation of the BadgerCare Medicaid Demonstration," RTI International, December 2003.

Hines, P., et al, "Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impacts in Multnomah and Washington Counties," The Office for Oregon Health Policy and Research, December 2003.

Hudman, Julie and Molly O'Malley, "Health Insurance Premiums and Cost-sharing: Findings from the Research on Low-Income Populations," Kaiser Commission on Medicaid and the Uninsured, March 2003.

Ku, L., Deschamps, E., and J. Hilman, "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program," Center on Budget and Policy Priorities, November 2004.

Ku, Leighton, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities, May 2003.

LeCouteur, G., Perry, M., Artiga, S., and D. Rousseau, "The Impact of Medicaid Reductions in Oregon: Focus Group Insights," Kaiser Commission on Medicaid and the Uninsured, December 2004.

Lowe, R.A., et al, "Changes in Access to Primary Care for Oregon Health Plan Beneficiaries and the Uninsured: A Preliminary Report Based on Oregon Health and Science University Emergency Department Data," The Office for Oregon Health Policy and Research, September 2003.

Maryland Department of Health and Mental Hygiene, Maryland Children's Health Program, "Assessment of the Impact of Premiums," April 2004.

McConnell, J. and N. Wallace, "Impact of Premium Changes in the Oregon Health Plan," The Office for Oregon Health Policy and Research, February 2004.

Office of Health Care Statistics, "Utah Primary Care Network Disenrollment Report, July-August 2003," Utah Department of Health, August 2004.

Office of the Executive Director, Utah Department of Health, "Medicaid Benefits Change Impact Study," 2003 Utah Public Health Outcome Measures Report, December 2003.

US General Accounting Office, "Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries," Washington, DC, March 2004, GAO-04-491.

Vermont Department of Prevention Assistance, Transition and Health Access, "Impact of Premiums on the Medicaid Program," April 2004.

Vern Smith et al., "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005: Results from a 50-State Survey," Health Management Associates for the Kaiser Commission on Medicaid the Uninsured, October 2004.

## Appendix A:
## Studies of the Impact of Recent Changes in Premiums and Cost Sharing in Medicaid, SCHIP, and Public Programs

| State | Study Title | Study Population/Data | Type of Analysis | Major Findings |
|---|---|---|---|---|
| **MD** | Maryland Children's Health Program: Assessment of the Impact of Premiums | Families with incomes between 185-200% FPL. | Enrollment data<br>Survey of 360 parents whose children disenrolled. | -About one-quarter of families subject to new premiums disenrolled.<br>-One in five cited a premium related reason for disenrollment. |
| **OR** | Impact of Premium Changes in the Oregon Health Plan | Parents and adults with incomes up to 100% FPL | OHP Standard enrollment data from January 2002 through October 2003. | Oregon experienced large enrollment declines following implementation of increased premiums and stricter premium payment rules. |
| | The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population | Parents and adults with incomes up to 100% FPL | Survey of 2,783 OHP Standard enrollees and disenrollees following implementation of premium and cost sharing increases and benefit reductions. | -Increased costs contributed to disenrollment and 67% of disenrollees became uninsured.<br>-Copayments impeded access to necessary care.<br>-Loss of coverage significantly increased the risk of an emergency department among those with the lowest incomes and those with a chronic illness. |
| | Coverage Reductions in Oregon: Focus Group Insights | Adults with incomes up to 100% FPL | Focus groups with OHP Standard enrollees and disenrollees following implementation of premium and cost sharing increases and benefit reductions. | -New premiums and stricter payment policies led to loss of coverage.<br>-Copayments are difficult to afford and impede access to needed care and prescription drugs. |
| | Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impact in Multnomah and Washington Counties | Health center administrators and physicians in Portland metropolitan area. | Structured interviews with administrators | Increased premiums and cost sharing contributed to increased pressures on safety net clinics. |
| | Changes in Access to Primary Care for Oregon Health Plan Beneficiaries and the Uninsured: A Preliminary Report Based on Oregon Health and Science University Emergency Department Data | Emergency department utilization data from Oregon Health and Science University Hospital | Compared data for the first three months after Medicaid program changes compared to the same three months the previous year | -Increase in uninsured patients<br>-Reduction in patients with Medicaid (OHP) coverage<br>-Large increases in uninsured visits related to alcohol and chemical dependency<br>-No changes in proportions of visits classified as "primary-care treatable, potentially avoidable, or unavoidable emergency" among uninsured and Medicaid beneficiaries |
| **RI** | Results of RIte Care Premium Follow-up Survey | Families with incomes 150%-250% FPL | Enrollment data<br>Survey of 552 disenrolled families | -Nearly one in five families subject to new premiums lost coverage<br>-The most common reason respondents gave for losing coverage was inability to afford the monthly premium (48% reported this)<br>-51% of disenrollees were uninsured |

| State | Study Title | Study Population/Data | Type of Analysis | Major Findings |
|---|---|---|---|---|
| **UT** | Utah Primary Care Network Disenrollment Report | Adults ages 19-64 with incomes below 150% FPL | Enrollment data<br>Survey of 517 disenrolled adults. | -27% of PCN enrollees were disenrolled between July-September 2003, when many enrollees were required to repay the annual enrollment fee to retain coverage<br>-29% of respondents indicated financial barriers to their re-enrollment<br>63% of respondents reported being uninsured |
| | 2003 Utah Public Health Outcome Measures Report: Medicaid Benefits Change Impact Study | Adult Medicaid beneficiaries subject to new copayments | Analysis of utilization data; survey of and focus groups with beneficiaries. | -Copayments did not have a statistically significant impact on utilization for most services<br>-Some beneficiaries expressed difficulty affording copayments |
| | The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program | Adult Medicaid beneficiaries subject to new copayments | Analysis of utilization data | Co-payments led to decreased utilization of services |
| **VT** | Impact of Premiums on the Medicaid Program | VHAP (50-185% FPL), SCHIP (185-300% FPL), and pharmacy coverage (150-225% FPL) beneficiaries | Enrollment data<br>Survey of disenrollees. | -About 11% were disenrolled for nonpayment or premiums one month after premiums increased<br>-Over a quarter (26%) of SCHIP respondents, 69% of VHAP respondents, and 42% of pharmacy coverage respondents reported that they disenrolled because of cost |
| **WA** | Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations | Low-income immigrant children and parents who lost Medicaid look-alike coverage and became eligible for the state-funded Basic Health program | Enrollment data<br>Structured interviews with key stakeholders<br>Focus groups. | -Less than half (48%) of families enrolled in Basic Health<br>-Most (61%) who enrolled in Basic Health relied on assistance to pay premiums<br>-Premiums were a significant barrier to families' obtaining and maintaining Basic Health coverage<br>-Families who transitioned to Basic Health reported difficulties affording copayments |
| **WI** | Evaluation of the BadgerCare Medicaid Demonstration | Families with incomes below 185% FPL | Enrollment data<br>Survey of 914 disenrollees | -Premium paying families were less likely to remain enrolled over time, but the difference from families not subject to premiums was small<br>-Premiums delay reenrollment of families<br>-The most frequently cited reason for disenrollment among respondents was a "premium-related reason" (26%) |

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