

medicaid and the uninsured

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The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program

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EXECUTIVE SUMMARY

Over the past three years, the fall off in state revenues, combined with rising health care costs, has prompted every state to make changes in its Medicaid program. States have relied on a wide array of cost-containment measures, but as the fiscal crises worsened, more states began to narrow the groups of people eligible for Medicaid, cut back on covered benefits, and increase costs for beneficiaries who remain eligible. Sometimes these actions were taken under options permitted by Medicaid rules; other times, a "Section 1115" waiver was sought because the measure went beyond what would have been permitted by Medicaid law. Although the fiscal situation is beginning to improve in some parts of the country, several states are still pursuing cost-cutting measures in their Medicaid programs and a few are planning broad-based waivers that could potentially restructure their entire Medicaid programs.

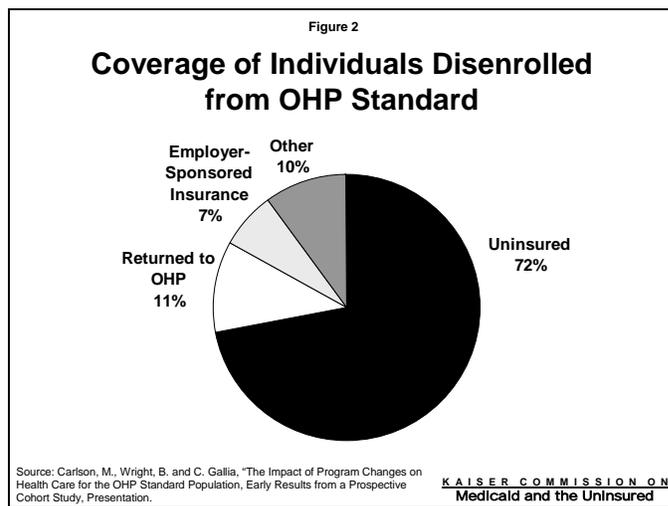
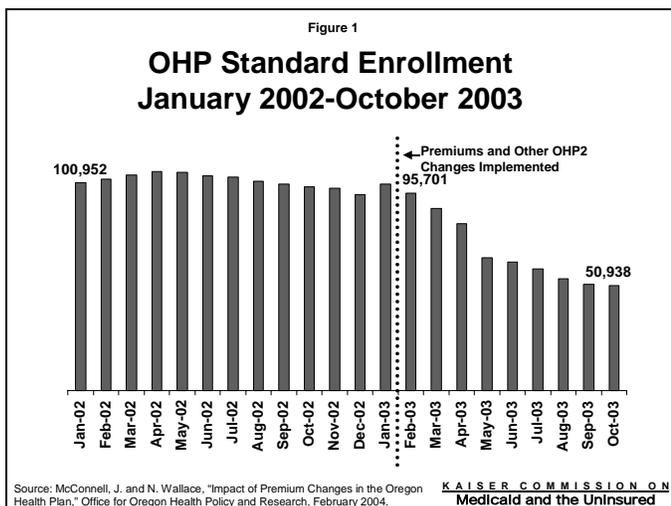
Oregon's experience may be instructive to states that are considering such changes. Oregon has taken a number of actions in response to particularly difficult state budget problems—its fiscal crisis began earlier than for many other states, and its budget problems have been exceptionally severe. In February 2003, through a Section 1115 waiver, Oregon gained authority to make sweeping revisions to its Medicaid program, the Oregon Health Plan (OHP), including benefit reductions and higher premiums and cost sharing for poor adults. Other program changes were also adopted outside of the waiver, most notably, the elimination of the state's Medically Needy program, which assisted people who have high medical expenses relative to their incomes.

Following these changes, the Office for Oregon Health Policy and Research, with assistance from the Office of Oregon Medical Assistance Programs, established a research collaborative to help inform state and national policymakers about the impact of the changes in the Oregon Medicaid program. The Oregon Health Research and Evaluation Collaborative produced several reports, research briefs, and research presentations that address the impact of the program changes. This report summarizes the key findings from this work, which represents some of the first analysis available about the impact of cost cutting changes that many states have implemented or are considering. Oregon's experience provides some important, early lessons:

Many of the people affected by the Medicaid waiver changes had very limited incomes and serious physical and mental health problems. While many of the recent changes in state Medicaid programs target eligibility groups classified as "optional" or "expansion," these categories are not solely based on income or medical need. Many people in these groups have

very low incomes and significant health care needs. Some adults affected by Oregon’s waiver reductions had no regular source of income. Early survey findings also show that almost half of the adults whose coverage was reduced reported having a chronic condition other than depression/anxiety (e.g., high blood pressure, asthma, or diabetes), and over a third reported a diagnosis of depression or anxiety.

Premiums led to significant Medicaid coverage losses and most of those who lost Medicaid became uninsured. Although Oregon’s waiver application states that the waiver was not intended to reduce the number of people covered under Medicaid, it appears that the new premiums and premium policies implemented under the waiver have caused tens of thousands of poor adults to lose Medicaid coverage. The new premiums (ranging from \$6-\$20 per month, based on income), although lower than premiums for a typical employer-based plan, appear to have been unmanageable for many of the people the program was intended to serve. In less than a year, enrollment among the group subject to premiums fell by about one half (Figure 1). An early survey found that nearly three quarters of those no longer enrolled in Medicaid became uninsured (Figure 2). The losses illustrate the difficulties low-income people face paying premiums, even those that appear relatively modest and that vary by income.



There were significant coverage losses among all people subject to premiums, but people with the lowest incomes had the greatest problems paying premiums. Under Oregon’s waiver, adults with incomes under poverty, including some with no ongoing source of income, are required to pay premiums. The studies found that enrollment was affected for all people subject to premiums, but those with no incomes were most likely to disenroll. New enrollments among those with the lowest incomes also dropped sharply—for those with no income, new enrollment stabilized at just over half the level observed before the changes.

People who lost coverage faced significant difficulties obtaining care. An early survey of people who disenrolled following the premium changes found significant access problems, with 60% reporting an unmet health need and nearly 80% reporting an unmet mental health need. Those with chronic conditions were particularly adversely affected.

Cost sharing and limited benefits made it more difficult for people enrolled in the program to obtain needed care. Nearly a third of adults remaining on the program after the waiver changes reported an unmet health care need due to cost sharing requirements or to the elimination of coverage for certain benefits. About half reported an unmet mental health need (mental health services were eliminated for certain adults). Physicians described instances in which people avoided seeking necessary care because of costs.

Losses in coverage dwarfed coverage gains because only some parts of the waiver were implemented. Like a number of recent waivers, Oregon's waiver included both coverage expansions and reductions. However, the waiver agreements between states and the federal government have not required states to move forward with the expansions as a condition of implementing the reductions. As such, while a waiver itself may represent a trade-off between expansions and cutbacks, actual implementation can strike a very different balance. Oregon's waiver, as approved, included significant coverage expansions, but most were not implemented. Thus, while the waiver application included an estimate that 60,000 people would gain coverage through the expansions, only about 2,000 people had gained new coverage as of late 2003. These coverage gains are far surpassed by the 50,000 who lost coverage.

The elimination of the Medically Needy program created access problems for people with significant medical needs. Outside of the waiver changes, the state also eliminated its Medically Needy program. Because the Medically Needy program served individuals with high medical expenses relative to their incomes, the individuals who lost Medically Needy coverage were, by definition, a group with substantial medical needs. These people were primarily low-income Medicare beneficiaries who relied on Medicaid for prescription drugs. A survey conducted after they lost Medicaid coverage found that most of these elderly and disabled people were having problems obtaining needed drugs, which, in light of their significant medical needs, could result in considerable harm to their health and to higher costs due to compromised care.

Medicaid reductions appeared to increase pressures on other parts of the health care system. One study looked at the experience of a major metropolitan hospital following the program changes. While this study did not control for other factors that may have influenced emergency department use, it found that the number of emergency room visits by uninsured patients increased by 17% in the three months after the Medicaid changes were implemented compared to the year prior. Emergency room visits increased significantly for alcohol use and chemical dependency, which is no longer covered for many adults under the waiver. Clinics also reported difficulties meeting patient needs stemming both from losses in coverage and, for those who remained covered, from reductions in benefits and increases in copayments.

Coverage reductions created short-term state savings, but they resulted predominately from reduced coverage and care. Premium collections actually declined in Oregon after the waiver changes because so many people subject to the new premiums were dropped from the program. Overall, state Medicaid savings were achieved because of the large, unanticipated enrollment loss. However, these state savings also resulted in a substantial loss in federal funding due to the loss of federal match funds. (In Oregon, the federal matching rate is 61%, meaning that for every \$100 in coverage reductions, Oregon spends \$49 less in state funds but loses \$61 in federal Medicaid matching funds.)

The findings from Oregon, while preliminary, provide an important first look at the potential implications of Medicaid program changes. People who rely on Medicaid have lower incomes and are in poorer health than the general population. The research in Oregon suggests that they do not fare well when costs for Medicaid coverage and care exceed their ability to pay or when the benefit package is reduced, leaving many of their medical needs uncovered. While changes such as reduced benefits and increased premiums and cost sharing can create short-term savings for a state, Oregon's experience shows they can result in large coverage losses and access problems for beneficiaries and give rise to new sources of stress for health care providers.

I. INTRODUCTION

Largely as a result of serious budget problems, Oregon restructured its Medicaid program through a Section 1115 waiver and other program changes. According to Oregon's waiver application and other official documents, Oregon's intent in restructuring Medicaid was to contain costs and to operate the program "in ways that parallel commercial health plans."¹

Following these changes, the Office for Oregon Health Policy and Research, with assistance from the Office of Oregon Medical Assistance Programs, established a research collaborative to help inform state and national policymakers about the impact of the changes in the Oregon Medicaid program.² The Oregon Health Research and Evaluation Collaborative produced several reports, research briefs, and research presentations that address the impact of the program changes (which are listed in Appendix A). This report summarizes the key findings from this work, which represents some of the first analysis available about the impact of cost cutting changes that many states have implemented or are considering.

Oregon's waiver did not change Medicaid eligibility levels and its stated intent was not to cut people off from coverage. Yet, the research reveals that, in the months following the implementation of the waiver, enrollment dropped by about 50,000 people. People with very low incomes and those with chronic illnesses and other significant health problems were particularly hard hit. Care appears to have been compromised both for those who lost their coverage as well as for many who remain enrolled. People have been unable to fill prescribed medications, some have had to forego buying food to afford their copayments, and the number of uninsured patients seeking care through the emergency room of a major hospital has risen. Many of the research findings are preliminary and important questions remain unanswered, but the enrollment data and the studies undertaken to date show that the changes have contributed to an increase in the number of uninsured people, compromised access to care, and resulted in new strains on the health care delivery system.

Oregon's program is continuing to undergo changes as the state faces yet another round of budget cuts following a referendum rejecting a recently enacted tax package. Whether or not further revisions are adopted in Oregon, these findings provide a window through which major programmatic changes that other states may be considering, including reduced benefits, premiums, higher copayments, and a tiered benefit structure, can be examined.

II. OVERVIEW OF CHANGES TO OREGON'S MEDICAID PROGRAM

Beginning in 2003, Oregon implemented a number of significant changes to its Medicaid program in response to the state's growing fiscal problems. The state obtained a Section 1115 waiver, which gave it authority to make sweeping revisions to its Medicaid program, including benefit reductions and higher premiums and cost sharing for poor adults. The state also adopted program changes outside of the waiver, most notably, eliminating its Medically Needy program, which assisted people who have high medical expenses relative to their incomes.

A. Waiver Changes

Oregon's Medicaid program, known as the Oregon Health Plan (OHP), has been operating under a Section 1115 waiver since 1994. In February 2003, Oregon obtained a new Section 1115 waiver that allowed it to make major changes in OHP, creating what is now called OHP2. (A detailed summary of the OHP2 waiver is available on the Kaiser Commission on Medicaid and the Uninsured website, www.kff.org/kcmu.³) The waiver gave the state authority to make reductions and expansions in coverage, as well as to refinance an existing state-funded premium assistance program. As the state's fiscal situation worsened, it implemented most of the waiver-approved reductions, but only a small portion of the expansions:⁴

- **Reductions.** The waiver allowed the state to reduce benefits, increase premiums and cost sharing, and cap enrollment for previously eligible poor parents and other adults. The state moved forward with the benefit reductions and increased premiums and cost sharing, and it plans to close new enrollment for these adults beginning July 1, 2004.⁵ However, as a result of a recent court order, the state will stop charging these adults copayments beginning June 19, 2004.⁶
- **Expansions.** The waiver authorized a small expansion for pregnant women and children (from 170% to 185% of the federal poverty level) and a larger expansion for parents and other adults (from 100% to 185% of poverty). The state implemented the expansion for pregnant women and children, but has not implemented the expansion for parents and other adults.
- **Refinancing.** Under the waiver, the state folded an existing state-funded premium assistance program, the Family Health Insurance Assistance Program (FHIAP), into its Medicaid program, enabling the state to receive federal matching funds for FHIAP enrollees and to open FHIAP to more people.⁷

As a result of how the waiver was implemented, it has resulted in some coverage gains, but the number of people gaining new coverage has been quite modest and well below projections. In the waiver application, the state estimated that the waiver would expand coverage to 60,000 people; however, as of September 2003, only about 2,000 people who had not been eligible for public coverage prior to the waiver were covered.⁸ This reflects the small expansion for pregnant women and children and in the FHIAP program. The numbers remain well below projections because the large expansion for parents and other adults has not been implemented.

In contrast to the expansions, all of the benefit reductions and new beneficiary costs were implemented. These changes were accomplished by dividing people who had been covered by OHP into two different types of coverage—OHP Plus and OHP Standard (Table 1).

Table 1: A Brief Overview of OHP Plus and OHP Standard

	OHP Plus	OHP Standard
Eligibility	Children & pregnant women 0-185% FPL SSI recipients (0-74%) FPL Parents receiving TANF (0-52% FPL) Adults receiving GA (0-43% FPL)	Parents 0-100% FPL, except those receiving TANF Other adults 0-100% FPL, except those receiving GA <small>(Includes people with disabilities who do not receive SSI. Individuals with access to employer-sponsored coverage, must enroll in FHIAP)</small>
State can cap enrollment?	No	Yes Enrollment will be closed on July 1, 2004
Premiums	None	\$6-\$20 per month, based on income
Benefits	Comprehensive, but state can reduce	Substantially reduced
Copayments	\$2-\$3 (pregnant women, children, and managed care enrollees exempt)	\$3-\$250 (preventive services exempt) Services can be denied due to inability to pay. <small>(As a result of a recent court order, the state will stop charging copays for OHP Standard enrollees beginning June 19, 2004.)</small>

Table Notes: TANF is Temporary Assistance for Needy Families; GA is general assistance

OHP Plus covers children, pregnant women, parents who receive TANF cash welfare payments (below 52% of poverty), elderly and disabled people, and other adults who receive state-funded general assistance welfare payments (below 43% of poverty) who were eligible for Medicaid in Oregon prior to the waiver. OHP Plus also covers children and pregnant women who became eligible under the waiver expansion (between 170% to 185% of poverty). OHP Plus remains an entitlement program, meaning that the state cannot cap or freeze enrollment for eligible individuals. OHP Plus enrollees are not subject to premiums. Adults, other than pregnant women, are charged “nominal” copayments at levels consistent with federal Medicaid rules if they are not enrolled in a managed care plan (most are in managed care). The waiver allows the state to reduce OHP Plus benefits through a new “streamlined process,” without having to seek new waiver authority from HHS.⁹ The state has taken this step since the waiver was approved.

OHP Standard covers poor parents and other adults who are not receiving TANF or general assistance, all of whom were eligible for Medicaid in Oregon before these recent changes. Under the new waiver, the state gained authority to cap enrollment for this group, to increase their premiums and cost sharing, and to reduce their benefits.

- The ability to cap enrollment permits Oregon to limit coverage on a first come first serve basis, rather than based on income or medical need. The state plans to close enrollment on July 1, 2004. Once enrollment is closed, new applicants will not be able to enroll. Further, current enrollees who lose their coverage for any reason will not be able to reenroll.
- All OHP Standard enrollees, including those with no income, pay monthly premiums ranging from \$6 to \$20, based on income. The state also implemented stricter payment policies: people are disenrolled if they miss one premium payment (the prior policy had been to disenroll at six-month eligibility reviews), nonpayment can no longer be “waived” for good cause;¹⁰ and people who are disenrolled are “locked out” and must wait six months to

reenroll. Once new enrollment is closed on July 1, 2004, people who are disenrolled will no longer be able to reenroll, even after the six-month lock-out period.

- Copayments are charged for most covered services (preventive services are exempt) and range from \$3 to \$250. Unlike OHP Plus enrollees, OHP Standard enrollees can be denied services if they cannot afford a copay. As a result of a recent court order, beginning June 19, 2004, the state will no longer charge copays for OHP Standard enrollees.
- Benefits have been reduced significantly below the OHP Plus levels. OHP Standard enrollees have no coverage for mental health and substance abuse services, durable medical equipment (such as wheelchairs), and dental and vision services. In March 2003, the Legislature also dropped prescription drug coverage, but later restored this coverage.
- People eligible for OHP Standard who have access to employer-sponsored insurance (ESI) are required to enroll in the FHIAP premium assistance program instead of OHP Standard. FHIAP will subsidize the purchase of the ESI plan, but, depending on the particular plan, the coverage may have higher costs and fewer benefits than OHP Standard.¹¹

B. Elimination of the Medically Needy Program

The state has taken other steps to reduce state Medicaid spending outside of the waiver. The most significant is that the state eliminated its Medically Needy program, which had provided partial Medicaid coverage to people with incomes somewhat above the OHP eligibility standards who have significant health care expenses. Nearly 9,000 people lost coverage (mostly for prescription drugs) as a result of this change.¹² (In March 2003, the Oregon Legislature restored coverage for certain transplant and HIV drugs.)

III. EARLY RESEARCH FINDINGS FROM OREGON

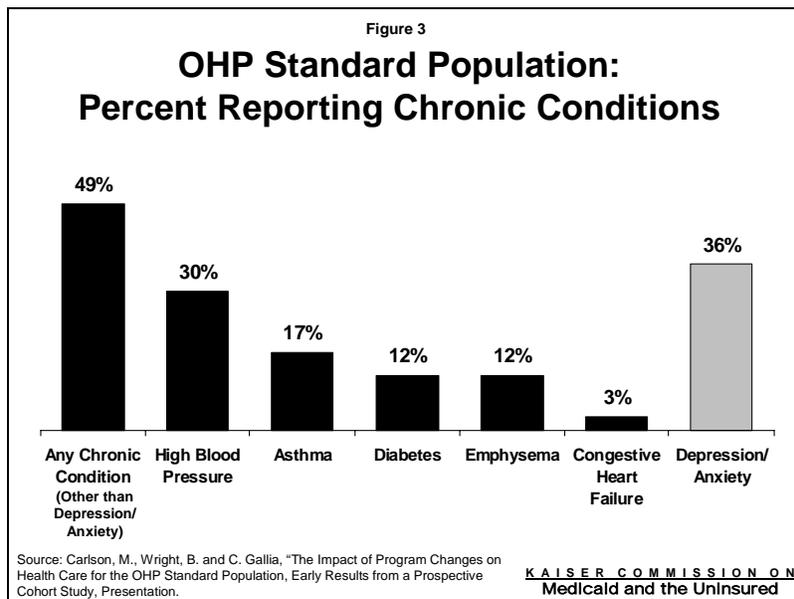
The Oregon Health Research and Evaluation Collaborative has produced several reports, research briefs, and presentations that address the impact of program changes. The major findings of this work are summarized below.

A. Individuals Impacted by Waiver Had Limited Incomes and Significant Health Needs

Individuals affected by the changes had very low incomes. The OHP Standard waiver changes affected “optional” or “expansion” eligibility groups—not people who states are required to cover under their Medicaid programs. Nonetheless, because of the way “mandatory” groups are defined under federal Medicaid rules, the changes still affected people with very low incomes and people with significant medical needs. Some of the affected adults had no regular source of income while others had incomes just above the cash assistance eligibility levels—43% of the federal poverty level for a childless adult (\$444 per month for an individual in 2004), and 52% of poverty for a parent (\$552 per month for two-person family in 2004).

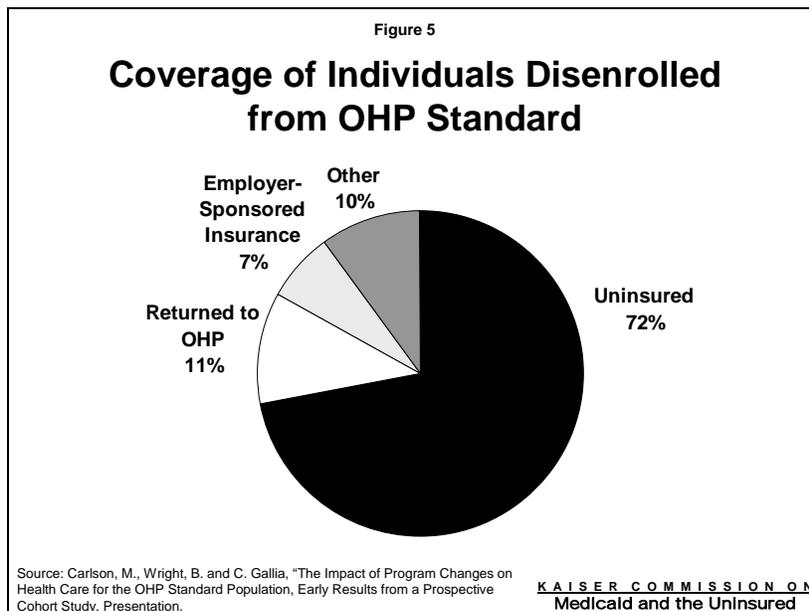
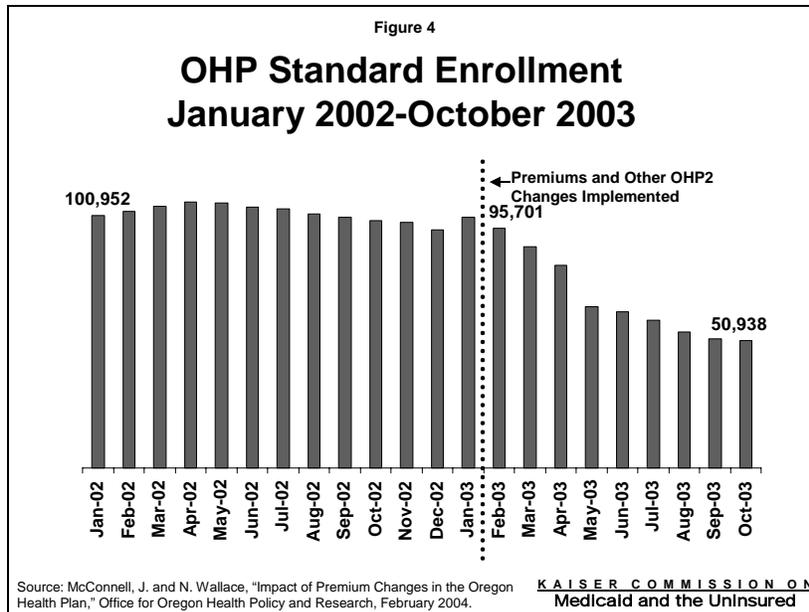
Many affected individuals had significant physical and mental health problems. Even though people who fall into the “disabled” eligibility category are not subject to the benefit, premium and cost sharing changes under the waiver, many of those affected by those changes had significant health care needs. Preliminary results from a statewide survey of the group

moved to OHP Standard found that almost half reported a chronic condition other than depression or anxiety, such as high blood pressure, asthma or diabetes, and 36% reported suffering from depression or anxiety (Figure 3).¹³ A second study focused on the impact of the elimination of mental health and substance abuse services for OHP Standard enrollees. Researchers examined data from one county and found that OHP Standard enrollees accounted for 29% of all OHP enrollees (Plus and Standard) with “severe persistent mental illness” and almost half (48%) of all OHP enrollees with a recent drug dependency diagnosis.¹⁴



B. Enrollment Declines

The waiver changes resulted in thousands of people losing Medicaid coverage and the majority became uninsured. Although the waiver was advanced as a way to stretch limited dollars in order to retain and even expand coverage, enrollment among those moved into OHP Standard has fallen sharply. In less than one year, the OHP Standard population fell by about one half—from over 100,000 enrollees in early 2002 to about 50,000 in late 2003 (Figure 4). Most of the change is the result of disenrollments, although researchers also observed considerable declines in new enrollments.¹⁵ Preliminary survey results found that nearly three quarters of OHP Standard disenrollees became uninsured (Figure 5).



Premium increases and stricter premium payment policies appear to be largely responsible for the drop in enrollment. Premiums are not new to Oregon’s Medicaid program. All of the adults moved into OHP Standard had been charged premiums under the original OHP waiver. Under the new waiver, the state increased the premium amounts to \$6-\$20 per month, based on income, and implemented stricter premium payment policies. While the premiums may still appear relatively modest, particularly when considering the cost of most private coverage, they played a significant role in the OHP Standard enrollment declines. In April 2003, the first month that OHP Standard enrollees were disenrolled for nonpayment of premiums, about 16,000 people were disenrolled for nonpayment, and between May and October 2003, about 31,000 more people were disenrolled for nonpayment.¹⁶ It is difficult, based on the available data, to determine how each of the premium-related changes have impacted enrollment. The Oregon

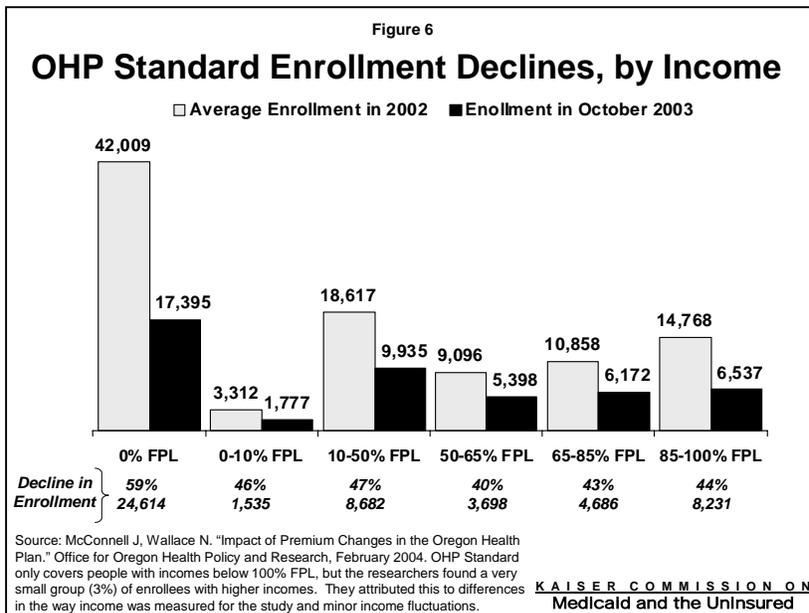
Department of Human Services generally attributes the coverage loss to the new premiums, and the researchers conclude that both the changes in the premium amounts and payment policies (along with some confusion about the changes) contributed to the loss of coverage.¹⁷ A survey of individuals moved to OHP Standard who left the program found that premium cost was the most common reason reported for loss of coverage.

Findings from other states....

Higher premiums also led to coverage losses in Massachusetts. Oregon's premium experience was mirrored in Massachusetts. Massachusetts has a health coverage program, funded through a surcharge on payroll, that offers insurance on a temporary basis to people who have lost their jobs and who are receiving unemployment insurance benefits. One month after the program began to charge premiums (\$20 per week for individual direct coverage plans and \$30 per week for family plans), enrollment declined by 34% to 48%. As occurred in Oregon, lower income people disenrolled at higher rates. The state has since reversed the policy. -From Seth Flagg, School of Medicine, Tufts University, "An Analysis of the Medical Security Plan during the Summer of 2003" (unpublished). Data on disenrollment from the Massachusetts Division of Employment and Training.

A repeal of premiums in Connecticut prevented coverage losses for SCHIP children. As many as 2,900 children, one-fifth of the 14,000 children enrolled in the state's SCHIP program, were slated to be disenrolled because their families did not pay new or increased premiums that were implemented in February 2004. According to the state, most of the children who would have lost coverage had incomes between 185-235% of poverty. The state legislature repealed the new premiums, preventing these coverage losses. -Covering Connecticut Kids and Families Update, www.childrehealthcouncil.org/covering.

There were significant Medicaid coverage losses among all those subject to premiums, but the lowest income people experienced the greatest losses. Oregon's experience demonstrates how difficult it is for low-income people to manage premiums, even premiums that appear to be relatively modest. OHP Standard covers individuals with incomes below 100% of poverty, and enrollment declined among every income group in OHP Standard (Figure 6).¹⁸ For example, enrollment dropped by 44% among those with incomes between 85%-100% of poverty. However, the decline was particularly steep for those at the very bottom of the income scale. More than half (59%) of people with no incomes, who had to pay a \$6 monthly premium, lost their OHP coverage. New enrollments among all income groups also dropped sharply after the new premium policies were implemented. Ten months after implementation, new enrollments for the lowest income group were a little above half the level they were prior to the recent waiver changes.¹⁹



Sponsorship of premiums has mitigated OHP Standard enrollment losses. The changes in OHP Standard enrollment data may, in fact, understate the impact that premiums can have on coverage for low-income people. For several months, providers in Multnomah County made payments to an independent nonprofit organization to pay premiums for thousands of people who were slated to lose coverage for nonpayment of premiums.²⁰ There are no reported data on the exact number of people whose coverage was preserved through these third party payments, but the number appears to be substantial.

Findings from other states....

In Washington and Utah, some individuals rely on sponsorship to afford public coverage. Nearly one in five (19%) enrollees subject to premiums in Washington's Basic Health program had their premiums paid by sponsoring organizations as of February 2003. These organizations also help individuals fill out their Basic Health enrollment and renewal forms. In Utah, the state's Primary Care Network program requires a \$50 enrollment fee for most enrollees (those who receive general assistance welfare payments pay \$15). Many individuals were having trouble affording the fee, and, in response, a number of community organizations developed sponsorship programs to help pay the enrollment fee as well as copayments. While the sponsorship in Washington and Utah helps some people afford coverage, this assistance is only available for a limited number of people and, in some cases, for a short period of time.

-From unpublished data from the Washington State Health Care Authority and a forthcoming report from the Kaiser Commission on Medicaid and the Uninsured.

C. Reduced Access to Care

Copayments have created barriers to care. Although data are not available showing whether utilization under OHP2 has been affected by copayments, other research has found that even relatively modest copayments, when imposed on very low-income people, can result in people not accessing necessary medical care.²¹ Initial reports suggest that this is the experience in Oregon as well. Physicians in the Portland metropolitan area describe instances where people have avoided seeking needed care because of the costs. They report that patients are "self-selecting not to schedule follow-up visits, and, as a result, their health outcomes are getting progressively worse." They also describe instances where patients have stopped taking or have cut back on prescribed medications because they cannot afford to fill prescriptions—"Some people are taking a pill every other day or they're cutting their pills in half. Patients are making all kinds of adaptations."²²

Relatively modest copayments can make it very hard for low-income people to access care

A recent focus group in Oregon revealed just how difficult it can be for people with limited incomes to come up with what may appear to be a very modest copayment and the lengths that people will go to in order to access care. One participant explained how she was able to pay the required copayments: "I buy those little packages of chips (with food stamps), and then I'd go out where people that have money are, during lunch you know, like at offices. I would sell for a quarter a piece, and sometimes I would get the \$2 that way."

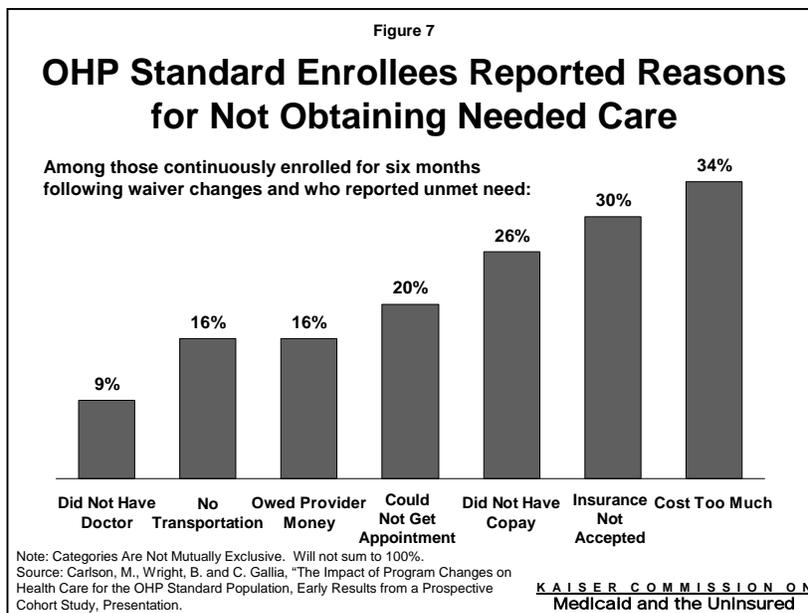
-From forthcoming report on focus groups findings from Oregon, Kaiser Commission on Medicaid and the Uninsured.

Two surveys of OHP2 enrollees offer somewhat mixed results. Health center patients surveyed at health centers did not report that they were missing appointments due to copayments, but the

researchers reasonably note that this group may constitute a biased sample for this particular inquiry, since they were already present at the health center.

Another study, referred to as the “baseline cohort” survey, involved a larger number people who were enrolled in OHP Standard as of February 2003, when the waiver changes were first implemented. The people surveyed included some who remained on the program during all or part of the six months following the changes and others who left the program after the changes. Preliminary results from this survey provide an important first look at how the changes may be affecting access to and

utilization of care, but it is important to recognize that the data are self-reported and preliminary, based on a 32% response rate. Among those who stayed continuously enrolled in OHP Standard following the waiver changes and who reported unmet need, 34% reported that they could not obtain needed care due to cost, 26% reported that copayments were a major factor in not getting care, and 16% reported that they did not get care because they owed the physician money (these factors were not mutually exclusive) (Figure 7).²³

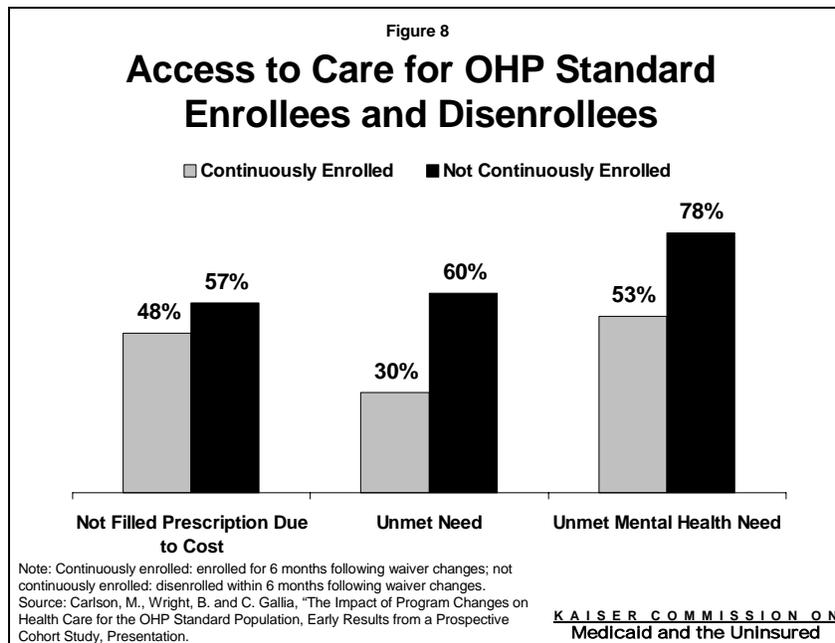


Avoiding care to avoid debt

Dr. X had a visit with a patient who was an asthmatic in acute distress. She had to keep the patient in her office for four hours trying to get him stabilized using a nebulizer. According to the doctor, “the patient really should have gone to the emergency department but the patient said, ‘I’m not going. I’ve got a bill. I don’t want to do it.’” The physician noted that these patients are not trying to get a free ride—“this guy could not breathe and he wasn’t going to do what he needed to do for fear of getting a bill. He didn’t even want to get an aerosol pump because he had to pay \$3 or \$5. The administrative team tried to ease his concerns by saying, ‘don’t worry about it’ but his response was, ‘well, I don’t want a bill! They’re sending me bills!’”

-From “Assessing the Early Impacts of OHP2: Pilot Study of Federally Qualified Health Centers Impacts in Multnomah and Washington Counties,” December 2003

Those who were disenrolled appeared to be even more likely to experience difficulties accessing care. The “baseline cohort” survey found that most of the people who lost their OHP Standard coverage had an unmet health care need, including some (self-reported) urgent needs. They were more likely than those who remained on the program to have not filled a prescription due to cost (57% versus 48%), to report unmet need (60% versus 30%), and to have unmet mental health needs (78% versus 53%) (Figure 8).²⁴ Disenrollees were also more likely to identify the emergency room as their usual source of care.



D. Access and Affordability Problems Due to Elimination of the Medically Needy Program

The elimination of the Medically Needy program created access problems for people with significant medical needs. One study surveyed a sample of people who lost Medically Needy coverage (a change adopted separate from the waiver as a result of additional budget cuts). The survey was conducted six months after the program was eliminated and most of the information was self-reported. Almost all (92%) of the people who lost Medically Needy coverage were low-income Medicare beneficiaries who had relied on Medicaid for prescription drug coverage and, in some cases, for mental health services.²⁵ Most of those who responded to the survey had been unable to access needed care after they lost their coverage. The majority (61%) reported that they had skipped doses or took less than the prescribed level of medication since they lost their coverage. Nearly two-thirds (64%) reported going without filling at least one recommended prescription.²⁶ The lack of prescription drug coverage could result in considerable harm to their health and to higher costs due to compromised care. Most have significant medical problems—over 85% reported they had two or more chronic conditions, and over two-thirds (68%) said they were in fair or poor health.²⁷

People who lost Medically Needy coverage have had to scramble to pay for care, often at the expense of other basic needs. The Oregon Medically Needy survey also found that 60% of those surveyed who had lost their coverage reported that they cut back on food purchases to pay for their medications. Almost half (49%) reported having to skip paying other bills or paying bills late. One fifth reported going into debt to pay for some of their prescriptions.²⁸

E. Pressure Shifts to Other Parts of Health Care System

Increases in emergency room visits by uninsured patients. One of the first studies conducted through the Oregon research collaborative examined changes in emergency room use at a large Portland hospital.²⁹ It compared emergency room use during the first three months following the Medicaid changes (March-May 2003) compared to the same months in the prior year (March-May 2002). Although the study did not control for other factors that might have affected utilization and the experience of the hospital might not be representative of experiences statewide, the results were notable. Visits to the emergency room by uninsured patients increased by 17% (from 2,064 to 2,406) while visits by patients covered by OHP dropped 20% (from 4,624 to 3,722). Visits by patients with commercial insurance also declined, although by a smaller percent and number (dropping by 8%, from 3,377 to 3,112). Because this preliminary analysis is based on data from the first three months following the waiver changes, these initial results could partially reflect instability created by the changes that will resolve over time.

Increases in emergency room visits for substance abuse treatment. Because OHP Standard enrollees no longer have coverage for substance abuse treatment, the researchers also looked at whether emergency room visits related to alcohol and chemical dependency increased following the waiver changes. They found that patient visits for alcohol use and chemical dependency rose by 26% (from 158 to 199) and 46% (from 54 to 79). The increase was particularly acute among patients who had no health insurance coverage. Alcohol-related visits by uninsured patients rose by 136% (from 33 to 78), while uninsured patient visits for chemical dependency treatment jumped by 200% (from 9 to 27).³⁰

Increased pressures on a Portland emergency room

The Oregon researchers concluded: "Although these results do not allow direct 'cause-and-effect' conclusions about the impact of the OHP changes on access to care, the data raise substantial concerns about access to medical care for Oregonians. Whatever the causes of the changed patterns of [emergency department] use, the increased use of the [emergency department] by the uninsured, especially for behavioral health problems, points to an urgent need to provide access to care for this population."

-From Lowe RA, 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," September 2003.

Increased pressures on safety-net clinics. Another study considered the impact of the Medicaid changes on health centers and their patients in the Portland metropolitan area. The interviews with administrators and providers surfaced a number of problems prompting a finding that the changes have had "a significant impact on the primary care delivered in safety net clinics."³¹ Administrators and physicians reported that they were diverting considerable clinic resources to finding sources of prescription drugs 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. Clinic physicians also expressed that they believe a growing number of private providers are "retreating" from treating Medicaid patients because they are unhappy with the new copayments and the added administrative burdens of dealing with the much more complicated, tiered system.

Stretched resources for the uninsured. Limited Oregon resources intended to serve those with no insurance now have to be stretched to meet the gaps in Medicaid coverage that have resulted from the program changes. When Portland area physicians saw that many of their Medicaid patients were not filling their prescriptions due to the copayments, they diverted some of the funds earmarked for the uninsured (a dispensary financed with a federal HRSA grant) to help assure that these “insured” patients had the prescriptions they needed.

Findings from other states

Coverage reductions in Washington State resulted in cost shifting. In 2002, Washington eliminated Medicaid look-alike coverage for about 28,000 low-income immigrant families. These families became eligible for the state’s Basic Health program, which, in contrast to Medicaid, had more application requirements, more limited benefits, and premiums and cost sharing. Early observations found that nearly half of the families did not make the transition to Basic Health, and many became uninsured. Further, Basic Health’s more limited benefits and its cost sharing requirements created access problems for some who did enroll. These coverage losses and gaps appeared to shift costs to other parts of the state’s health care safety net: the state legislature appropriated some short-term dollars for dental care and medical interpretation to help fill the gaps in coverage created by the transition; some providers increased their provision of charity care for uncompensated services; and public health agencies provided staff resources for outreach or identified temporary funding sources to help pay for non-covered care for families involved in the transition.

-From 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.

Short-term savings may have been achieved, but not through premium collections. Before the OHP2 changes, the state collected about \$900,000 in premiums on a monthly basis. As a result of lower-than-projected enrollment, premium receipts dropped to about \$500,000 a month by the end of 2003.³² Ironically, the state collected more revenues through premiums prior to OHP2. On an annual basis, about \$9.6 million in premium revenues were collected in 2000, compared to about \$6 million at current collection rates. The state has certainly seen its state spending under OHP Standard fall, but this is due to lower enrollment, not higher premium collections. At the same time, Oregon, with a 61% Medicaid federal match rate, also has had a substantial loss in federal funding as a result of the loss of federal match funds.

IV. POLICY IMPLICATIONS

Much of the Oregon research is preliminary. Time has not allowed for an extensive examination of utilization data, a look at how the changes may have impacted health status, or consideration of the extent to which factors other than the Medicaid changes may have contributed to the observed problems. Nonetheless, these “real time” studies offer valuable information that has an inherent logic. Medicaid serves a particularly vulnerable population—people with low incomes, including many with considerable medical needs. Basic features of the program, including cost sharing rules, premium policies, and benefit standards were designed with this population in mind. As such, changes to these core elements of the program have significant implications. Oregon’s early experience provides some important early lessons:

- Many people in the “optional” or “expansion” eligibility groups who were affected by the waiver changes had very low incomes and significant physical and mental health problems.
- Premiums led to significant Medicaid coverage losses among low-income families.

- The lowest income people had the most difficulty paying premiums.
- Limited benefits and above-nominal cost sharing appeared to create barriers to accessing necessary care for those who remained enrolled.
- People who lost Medicaid coverage were even more likely to experience difficulties obtaining care.
- Reductions in Medicaid increased pressures on other parts of the state's health care system in a number of different ways.
- Higher premiums created savings for the state, but the savings came through reduced coverage and care, not increased premium collections.
- Because state Medicaid spending is matched with federal funds, state savings also resulted in the loss of federal matching payments.

Change in the Medicaid program, prompted largely by rising costs and the aging population, needs to take into account the particular needs of the people served by the program. Medicaid beneficiaries have low incomes and generally are in poorer health than the rest of the population. Benefit restrictions and higher costs that people with more income or in better health might be able to manage can result in major access barriers, sometimes with devastating results,³³ for the Medicaid population. The early evidence from Oregon suggests the changes that many states are undertaking or considering will likely create a range of new problems with significant consequences for people and the health care delivery system.

Prepared by Cindy Mann of the Georgetown University Health Policy Institute and Samantha Artiga of the Kaiser Commission on Medicaid and the Uninsured. The authors thank the Oregon Health Research and Evaluation Collaborative research staff and principal investigators for their helpful review and comments on this brief. They also thank Victoria Wachino, Barbara Lyons, and Diane Rowland at the Kaiser Commission on Medicaid and the Uninsured for their guidance and assistance and Fouad Pervez at the Georgetown University Health Policy Institute for his research assistance.

APPENDIX A: OREGON REPORTS, RESEARCH BRIEFS, AND PRESENTATIONS

(Available at <http://www.ohpr.state.or.us/OHREC%20welcome2.htm>)

Reports

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.

Lowe RA, 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

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

Zerzan J. "Oregon's Medically Needy Program Survey." The Office for Oregon Health Policy and Research, February 2004.

Research Briefs

"Individual Characteristics of Patients in the OHSU Emergency Room." Oregon Health Research and Evaluation Collaborative, February 2004.

Wheeler R. "Projected Impact of Oregon Health Plan Changes: A Combined Data Set Analysis in Lane County." Oregon Health Research and Evaluation Collaborative, June 2003.

Zerzan J. "The Medically Needy Program Survey." Oregon Health Research and Evaluation Collaborative, October 2003.

Presentations

Carlson M, Wright B. "The Impact of Program Changes on Health Care for the OHP Standard Population: Early Results from a Prospective Cohort Study." The Office for Health Policy and Research and the Office of Medical Assistance Programs.

Center for Policy and Research in Emergency Medicine, Oregon Health and Science University. "Changes in Access to Primary Care for Oregon Health Plan Beneficiaries and the Uninsured: A Preliminary Report."

Edlund T. "Individual Characteristics of Patients in the OHSU Emergency Department." The Office for Oregon Health Policy and Research, February 2004.

Hartung D. "An Evaluation of Prescription Drug Copayments in the Oregon Health Plan: Preliminary Analysis." Oregon State University College of Pharmacy.

McConnell J, Wallace N. "Changes in enrollment Among OHP Standard Clients with OHP2 Implementation." The Office for Health Policy and Research, and the Office of Medical Assistance Programs, January 2004.

Zerzan J. "Survey of Oregon's Medically Needy Program Participants." The Office for Oregon Health Policy and Research.

ENDNOTES

¹ State of Oregon 1115 Waiver Amendment Application, May 31, 2002; Oregon Department of Human Services, Legislative Wrap-up, March 3, 2004, <http://www.dhs.state.or.us/publicatons/reports/03session>

² The research has been supported by a grant from the Robert Wood Johnson State Coverage Initiatives. The Oregon Health Research and Evaluation Collaborative engages “Oregon health services researchers, state agencies, stakeholders and advocates sharing and studying the impact of changes to the Oregon Health Plan.” See, <http://www.ohpr.state.or.us/OHREC%20welcome2.htm>

³ “Oregon Section 1115 Waiver Fact Sheet,” Kaiser Commission on Medicaid and the Uninsured, <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14330>

⁴ Under the terms and conditions of most section 1115 Medicaid waivers, states can pick and choose which parts of a waiver they will implement. Even if a waiver includes coverage improvements, they typically do not require the state to implement the improvements as a condition of moving forward with the newly authorized restrictions.

⁵ DHS Director’s Weekly Message (week of May 24), Oregon Department of Human Services, <http://www.dhs.state.or.us/news/messages/2004messages/2004-0528.html>.

⁶ DHS Director’s Weekly Message (week of May 24), Oregon Department of Human Services, <http://www.dhs.state.or.us/news/messages/2004messages/2004-0528.html>.

⁷ Under FHIAP, the state provides individuals subsidies for the purchase of private individual or group coverage.

⁸ C. Mann, S. Artiga, J Guyer, *Assessing the Role of Recent Waivers in Providing New Coverage*, for the Kaiser Commission on Medicaid and the Uninsured, December 2003.

⁹ The original OHP waiver allowed the state to restrict services based on a prioritized list. Under that waiver, if the state wanted to reduce the level of services provided (beyond the levels approved in the initial waiver), it was required to seek HHS approval. Under the new waiver, the state was granted authority to restrict services through its prioritized list under a streamlined process that, according to conversations with CMS, has yet to be determined. See Oregon Waiver Application, May 31, 2002, page 13, Terms and Conditions, October 15, 2002, page 10; Operational Protocol, February 1, 2003, Section 4-1.

¹⁰ Before the OHP2 changes, people could have their premiums waived if they met certain criteria, including not having any income at the time of application or reapplication and for the previous two months, being a victim of a crime that caused the loss of income or resources, being a victim of domestic violence, being a victim of a natural disaster, being homeless, losing housing, or having filed for bankruptcy.

¹¹ As a condition of receiving federal matching payments for FHIAP, some minimum standards were imposed on the coverage subsidized through FHIAP. Even with those standards, subsidized coverage can have more limited benefits and higher beneficiary costs than the OHP Standard package. FHIAP enrollees could be subject to up to a \$500 deductible and total out-of-pocket costs up to \$2,500, in addition to cost sharing for prescription drugs.

¹² Zerzan J, et. al. “Oregon’s Medically Needy Program Survey.”

¹³ Carlson M, Wright B. “The Impact of Program Changes on Health Care for the OHP Standard Population: Early Results from a Prospective Cohort Study.”

¹⁴ Wheeler R. “Projected Impact of Oregon Health Plan Changes: A Combined Data Set Analysis in Lane County.”

¹⁵ About the same number of people disenrolled before and after the changes (over a comparable period of time), but the data show that in the past many of the people who disenrolled re-enrolled within a relatively short period of time. This has not been the pattern under OHP2 in part because the waiver allows the state to deny re-enrollment for six months to people disenrolled for nonpayment of premiums. Since the data analyzed to date is based on less than a full year of operation, more research is needed to determine whether people re-enroll after the six-month lock out; however, people will no longer be able to re-enroll when enrollment is closed on July 1, 2004. New enrollments dropped as soon as the changes were implemented in February and March 2003. The number of new enrollments stabilized in October 2003, but at levels about 40 percent below new enrollment for the previous year, McConnell J, Wallace N. “Impact of Premium Changes in the Oregon Health Plan.”

¹⁶ McConnell J, Wallace N. “Impact of Premium Changes in the Oregon Health Plan.” pp 4, 8. An additional 35,377 people left the program voluntarily for a total loss of 66,346 during this period.

¹⁷ McConnell J, Wallace N. “Impact of Premium Changes in the Oregon Health Plan.” See also Oregon Department of Human Services: Legislative Session Wrap-up, March 5, 2004, <http://www.dhs.state.or.us/publications/reports/03>. A preliminary analysis of the impact of the OHP program changes found that beneficiary costs (premiums and copayments) were the major drivers of the coverage losses. Carlson M, Wright B. “The Impact of Program Changes on Health Care for the OHP Standard Population: Early Results from a Prospective Cohort Study.”

¹⁸ Researchers found a very small (3%) group of OHP2 enrollees had incomes above 100% of poverty. They attributed this to differences in the way the income was measured for purposes of the study and minor income fluctuations.

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- ¹⁹ McConnell J, Wallace N. “Impact of Premium Changes in the Oregon Health Plan.”
- ²⁰ Communications with Jane Perkins, National Health Law Program, April 27, 2004 and Heather Domenick, Central City Concern, May 28, 2004.
- ²¹ Tamblyn R et al. “Adverse events associated with prescription drug cost sharing among poor and elderly persons.” Ku L. “Charging the Poor More for Health Care: Cost-Sharing in Medicaid.” Hudman J, O’Malley M. “Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations.”
- ²² Hines P, et. al. “Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impacts in Multnomah and Washington Counties.”
- ²³ Carlson M, Wright B. “The Impact of Program Changes on Health Care for the OHP Standard Population: Early Results from a Prospective Cohort Study.”
- ²⁴ Ibid.
- ²⁵ Zerzan J. “Oregon’s Medically Needy Program Survey.”
- ²⁶ Ibid.
- ²⁷ Ibid.
- ²⁸ Ibid.
- ²⁹ Lowe R, et. al. “Changes in Access to Primary Care for Oregon Health Plan Beneficiaries and the Uninsured: A Preliminary Report Based on OHSU Emergency Department Data.” The report relies on data from the Oregon Health and Science University (OHSU) emergency department. According to the researchers, “This is a preliminary report of a project that will eventually analyze a full year of data after the OHP changes. However, given the need to evaluate the impact of the OHP changes as soon as possible, this preliminary report has been prepared, looking at the first three months of data.
- ³⁰ Lowe R, et. al. “Changes in Access to Primary Care for Oregon Health Plan Beneficiaries and the Uninsured: A Preliminary Report Based on OHSU Emergency Department Data.”
- ³¹ Hines P, et. al. “Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impacts in Multnomah and Washington Counties.”
- ³² McConnell J, Wallace N. “Impact of Premium Changes in the Oregon Health Plan.”
- ³³ The news media in Oregon reported the death of Douglas Schmidt, 37. According to newspaper reports, he suffered a massive epileptic seizure on March 1, 2003, eight days after his anti-seizure medication ran out. Schmidt was one of thousands of Oregonians who lost Medically Needy coverage for medications in February 2003. According to the reports, the total cost of Schmidt’s care (following the seizure until his death) was estimated by his family to be close to \$1 million. His seizure medication cost \$13 per day, *The Oregonian*, “The Death of Douglas Schmidt,” November 19, 2003; Colburn D; *The Oregonian* “Man dies after being taken off life support., November 19, 2003; Kramer A, KATU 2 News (Portland, Oregon) “Patient who became a poster child in health care debate dies,” November 18, 2003.

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